BY THE U.S. GENERAL ACCOUNTING OFFICE

Report To The Secretary Of Health And Human Services

Federal Oversight Of State Medicaid Management Information Systems Could Be Further Improved

Federal management and oversight of State Medicaid Management Information Systems has improved since GAO's last review in 1978. However, the accuracy and completeness of system evaluations could be improved by adding certain evaluation criteria not now included, such as economy of operation and the contributions of surveillance and utilization review activities. Better guidance on how certain personnel costs should be allocated by the States would improve the accuracy of system cost reporting. Better enforcement of regulations requiring prior Federal approval or prior notice of certain equipment and service acquisitions would help to assure that system changes and improvements are needed, cost effective, and entitled to enhanced Federal funding.

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UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

HUMAN RESOURCES
DIVISION

B-208242

The Honorable Richard S. Schweiker
The Secretary of Health and
Human Services

Dear Mr. Secretary:

This report discusses the results of our review of the Medicaid Management Information System, which is administered on the Federal level by the Department of Health and Human Services' Health Care Financing Administration. It also discusses recent efforts to improve Federal management of the system and makes recommendations to you directed at improving Federal oversight of State operations.

We recognize that recent Administration proposals, such as Federalizing the Medicaid program and/or establishing a welfare administration block grant, could affect the conclusions and recommendations reached in this report. However, as discussed more fully in the report, we believe that the adoption of such proposals would not change the basic premises used in the formulation of these conclusions. For example, there will be a continuing need to evaluate claims processing and surveillance and utilization review activities and to oversee, control, and accurately report system costs regardless of Medicaid's future administrative structure.

As you know, section 236 of the Legislative Reorganization Act of 1970 requires the head of a Federal agency to submit a written statement on action taken on our recommendations to the Senate Committee on Governmental Affairs and the House Committee on Government Operations not later than 60 days after the date of this report and to the House and Senate Committees on Appropriations with the agency's first request for appropriations made more than 60 days after the date of the report.

Copies of this report are being sent to the above-mentioned Committees, the Senate Special Committee on Aging, the Senate Committee on Finance, and the House Committee on Ways and Means; the Director, Office of Management and Budget; your Inspector General; the Administrator of the Health Care Financing Administration; and other interested parties.

We would appreciate being advised of your views and any action you plan to take regarding the matters discussed in this report.

Sincerely yours,

Gregory J. Ahart
Director

GENERAL ACCOUNTING OFFICE
REPORT TO THE
SECRETARY OF HEALTH AND
HUMAN SERVICES

FEDERAL OVERSIGHT OF STATE MEDICAID MANAGEMENT INFORMATION SYSTEMS COULD BE FURTHER IMPROVED

D I G E S T

In 1972, the Congress authorized incentive funding for States to design, develop, and install (90-percent Federal funding) and operate (75-percent Federal funding) mechanized claims processing and information retrieval systems for Medicaid--called Medicaid Management Information Systems (MMISs). The intent was to make program administration more efficient, economical, and effective. In a 1978 report, GAO stated that the Department of Health and Human Services (HHS) was approving systems as operational without assuring that the expected benefits could be realized. Many other problems with the systems were also reported.

In 1980, the Congress passed the Schweiker Amendment, which required most States to install a mechanized system and HHS to assure that the systems were operating as intended. This review was made to evaluate HHS' actions in response to GAO's earlier report and to the revised law.

In fiscal year 1981, 35 States operated approved systems at a cost of $214 million, and 21 States (12 of which had approved systems) spent $48 million on systems design, development, and installation.

At the Federal level, the Medicaid program is the responsibility of the Secretary of HHS, and it is administered by the Health Care Financing Administration (HCFA).

NEED TO EXPAND PERFORMANCE EVALUATION

The newly designed Systems Performance Review, which contains the performance standards developed in response to the revised law that approved systems must meet, has been successful in identifying some program weaknesses. While the performance standards include measures of system effectiveness and efficiency, economy of operations--a

major purpose of the MMIS--is not measured. Thus, HHS does not know whether the States' systems are meeting standards at a reasonable cost.

Although HCFA recognizes the need to evaluate operational economy, it has deferred action in this regard in anticipation of HHS' requiring, as recommended by GAO in its earlier report, that States implement a functional cost reporting system to assure accurate and comparable cost data. HHS has no current plans to do so, but GAO continues to believe a functional cost reporting system is needed. On an interim basis, HCFA should develop a measure of operational economy from cost and workload information which States are currently required to report. (See pp. 8 and 9.)

Current performance standards do not include any measures of the States' effectiveness in identifying and correcting program misutilization by Medicaid providers and recipients or the contributions of the Surveillance and Utilization Review subsystem to that activity. Therefore, HHS has little assurance that increased Federal funding for operating this subsystem is justified.

Although previous efforts have been unsuccessful, HHS needs to continue exploring ways to develop equitable standards for surveillance and utilization review accomplishments. In the near term, HHS should at least measure and assess the subsystem's contributions to accomplishments in identifying and correcting abusive Medicaid practices. (See pp. 10 to 13.)

GAO found that States were having problems with Surveillance and Utilization Review subsystem methodology which affected to some degree the accuracy of the subsystem in identifying potential misutilizers. For example, three of the four States GAO visited did not have a mechanism for developing complete claims histories on physicians who were members of group practices or who had more than one identification number.

HHS is considering adding some requirements to the performance evaluation directed at assessing data accuracy. HHS should establish, and require States to use, certain basic methods of developing system data to assure at least a minimum level of accuracy. (See pp. 13 to 16.)

FURTHER IMPROVEMENTS NEEDED IN OVERSIGHT OF STATE EXPENDITURES FOR MMIS OPERATIONS

GAO found that States (1) were underreporting systems operating costs and (2) had proceeded with purchases of automatic data processing (ADP) equipment or services without obtaining required HHS prior approval.

Because the level of Federal funding is the same for skilled professional medical personnel and MMIS operations, the States GAO reviewed generally reported one total figure for all such personnel separate and apart from MMIS costs, rather than allocating the appropriate portion of personnel costs to MMIS. As a result, the total MMIS costs reported by these States were understated. HHS needs to clarify cost reporting guidelines to assure that (1) appropriate personnel costs are allocated to MMIS operations and (2) those costs are sufficiently accurate for use by HHS in comparing system operational economy among the States. (See pp. 19 to 22.)

Although HHS regulations require States to obtain prior approval or give prior notice to HHS before purchasing ADP equipment and services exceeding certain dollar thresholds, the HCFA-issued State Medicaid Manual requires States to follow this procedure only when they desire 90-percent Federal funding for systems design, development, or installation. GAO found instances where States made purchases exceeding the dollar thresholds and received 75-percent Federal funding without obtaining prior approval. HCFA needs to revise the State Medicaid Manual so that it is consistent with HHS regulations and thus provides HHS and HCFA central office systems personnel an opportunity to review the merits of these projects. (See pp. 22 to 25.)

RECOMMENDATIONS

We recommend that the Secretary of HHS direct the Administrator of HCFA to

--include in future System Performance Review standards and methodology, requirements for (1) operational economy, (2) system effectiveness in identifying and correcting program

misutilization, (3) Surveillance and Utilization Review subsystem contributions to overall surveillance and utilization review accomplishments, and (4) exception process methodology to better assure the accuracy of that subsystem's data;

--clarify instructions for reporting Medicaid administrative costs to assure that costs of personnel who may qualify as skilled professional medical personnel but are engaged in MMIS functions be reported as MMIS operations costs; and

--revise the State Medicaid Manual so that it is consistent with the HHS regulation which requires prior approval or advance notice of ADP equipment and services purchases.

Contents

ABBREVIATIONS

ADP	Automatic data processing
GAO	General Accounting Office
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
MMIS	Medicaid Management Information System
SPR	Systems Performance Review
S/UR	Surveillance and Utilization Review subsystem

CHAPTER 1

INTRODUCTION

Rapidly rising Medicaid costs and program management inadequacies have caused continued concern in the Congress, the executive branch, and the States throughout the life of the Medicaid program. To address some of these concerns, the Federal Government funded development of State Medicaid Management Information Systems (MMISs). An MMIS is an automated system used to pay claims for services rendered to Medicaid recipients and to provide information necessary to manage and control a State's Medicaid program.

In a September 1978 report to the Permanent Subcommittee on Investigations, Senate Committee on Governmental Affairs, 1/ we discussed various problems which were limiting the benefits of MMIS, including:

--The Department of Health and Human Services (HHS) was reimbursing States at the 75-percent rate merely for having an approved system, rather than on the basis of performance. We recommended that HHS develop standards of economy, efficiency, and effectiveness and periodically determine whether each system was performing according to those standards.

--HHS had not clearly defined which State costs could be included as MMIS costs and did not require States to report details on their information systems costs. We recommended that HHS clearly define allowable MMIS operating costs and develop and implement a functional cost reporting system so that it could be determined whether States met MMIS performance standards at a reasonable cost.

This report discusses HHS' recent efforts to implement prior GAO recommendations and to further improve Federal management of the MMIS program.

BACKGROUND

The Medicaid program is authorized by title XIX of the Social Security Act, enacted in 1965. It is a Federal/State program which makes payments to medical service providers on behalf of eligible patients. At the Federal level, the Medicaid program is the responsibility of the Secretary of HHS and is administered by the Health Care Financing Administration (HCFA). The Secretary,

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1/"Attainable Benefits of the Medicaid Management Information System Are Not Being Realized" (HRD-78-151, Sept. 26, 1978).

through HCFA, provides regulatory guidance and Federal financial support. Each State tailors its program to its own needs, choosing from many options related to eligibility and services.

The Federal Government now pays, depending on State per capita income, 50 to about 78 percent of each State's Medicaid program costs. State and local governments pay the remaining 50 to 22 percent. The Federal Government also generally pays 50 percent of the States' administration and training costs incurred in operating the program. Total Medicaid expenditures by 49 States (Arizona did not have a program), the District of Columbia, Guam, the Northern Mariana Islands, Puerto Rico, the Virgin Islands, and the Federal Government for providing medical services to about 22.4 million people in fiscal year 1981 was about $28.8 billion. Total administrative and training costs for the program for fiscal year 1981 was an additional $1.5 billion.

Increased Federal funding authorized for MMIS

To encourage each State to implement a mechanized claims processing and information retrieval system, the Social Security Act (section 1903(a)(3)) authorized HHS to pay 90 percent of States' costs to design, develop, and install an MMIS and 75 percent of the States' costs to operate the system. Although this enhanced Federal funding was authorized (Public Law 92-603, Oct. 30, 1972) to provide more efficient, economical, and effective administration of the Medicaid plan, the authorizing legislation does not define the terms efficient, economical, or effective.

In implementing the legislation, HHS issued a general conceptual system design for MMIS which States were to use in establishing their own system to meet basic system objectives and their own individual State needs. Compliance with the objectives and functions of this conceptual design, usually referred to as the general systems design, is a basic requirement for States to receive HHS approval and continued enhanced Federal funding for MMIS. The general systems design for MMIS includes six subsystems: recipient, provider, claims processing, reference file, surveillance and utilization review, and management and administrative reporting. The first four subsystems work together in processing claims and paying eligible providers. The other two subsystems consolidate and organize data from which reports, necessary for managing and controlling the Medicaid program, are prepared.

As of March 1982, HHS had approved MMIS systems in 37 States. 1/ Since receiving approval, four of these States 2/ have installed new updated systems which have not yet been approved. An additional two States and the District of Columbia have operational mechanized systems awaiting HHS approval, five States are in various stages of design and development, and five States and four jurisdictions have no current plans to develop an MMIS. (See app. I.) In fiscal year 1981, 35 States 3/ reported spending about $214 million for MMIS operations and 21 States, including 12 with approved systems, reported spending about $48 million for MMIS design, development, or installation.

HHS initiatives to improve MMIS

In January 1979, following issuance of our report, the HCFA Administrator established an MMIS Task Force to identify changes which should be made to strengthen MMIS. The Task Force, which included representatives of various components within HHS and the States, addressed what it considered to be three "key areas": (1) development of MMIS performance standards, (2) improvements to MMIS general systems design, and (3) better Federal management of the MMIS program. The Task Force report, dated August 1979, 4/ made several recommendations which paralleled ours in each of the three areas, including

--output performance standards should be developed for approved MMIS;

--the general systems design should be updated, with particular emphasis on the surveillance and utilization review (S/UR) and the management and administrative reporting subsystems; and

--the types of costs which are allowable as MMIS operating costs should be clarified.

1/Includes New York, which is being approved on a regional basis.

2/Louisiana, Montana, Tennessee, and Vermont.

3/Pennsylvania and West Virginia did not receive systems approval until fiscal year 1982 and therefore did not report any MMIS operations costs in fiscal year 1981.

4/"Medicaid Management Information System Report: Steps for Its More Effective Use in The Coming Decade."

MMIS performance standards developed

The work begun by the Task Force ultimately resulted in a set of MMIS performance standards and methodology for evaluating State compliance with these standards. This package, called the Systems Performance Review (SPR), was developed in cooperation with the Systems Technical Advisory Group, consisting of representatives of State Medicaid Agencies. While the primary purpose of the SPR is to determine whether each State with an approved MMIS should continue to receive enhanced (75 percent) Federal funding to operate the system, it also assists the State in identifying needed improvements in system operation and administration. HCFA plans to review, refine, and update the SPR standards and methodology each fiscal year. The original version was field tested in fiscal year 1981. Revisions were made for fiscal year 1982, and work is in process on developing the SPR for fiscal year 1983.

In accordance with recommendations in our 1978 report, the Social Security Act was amended 1/ to require the Secretary to develop MMIS performance standards and system requirements, review each approved State MMIS at least once each fiscal year, and either reapprove or disapprove each system. The SPR is being used to meet these provisions of the act. States with an MMIS which do not meet all the SPR standards in fiscal year 1982 are subject to financial penalties--i.e., reduction in the 75-percent Federal share of MMIS operating costs. Under the 1981 SPR field test, 20 of the 29 States evaluated would have been assessed penalties.

General systems design for S/UR subsystem being upgraded

In 1979, HCFA also established a Surveillance and Utilization Review Advisory Panel to develop a set of practicable recommendations for upgrading the general systems design for the S/UR subsystem. The Advisory Panel, which, like the MMIS Task Force included State Medicaid Agency representatives, made its recommendations in October 1980. 2/ Using these recommendations as a guide, HCFA prepared a revised general systems design for the S/UR subsystem and in December 1981 invited States to submit proposals to pilot test, validate, implement, and evaluate the design. The revised general systems design will not become effective until this evaluation has been completed and any revisions or refinements indicated by the evaluations are made.

1/Section 1903(r), which was added to the Social Security Act by Public Law 96-398 (the Schweiker Amendment), dated Oct. 7, 1980.

2/"A Surveillance and Utilization Review Subsystem Perspective For The Eighties," Oct. 1, 1980.

MMIS administration costs now reported

HCFA has also taken action to increase its oversight of Medicaid administration costs. In June 1980, HCFA assessed the feasibility of requiring States to report costs on a functional basis. That assessment indicated that, while States would incur varying degrees of startup problems, a functional cost reporting system was feasible. Although HCFA has not made a final decision on whether to implement a functional cost reporting system, since January 1979, HCFA has required States to identify separately costs of the Medicaid program attributable to MMIS operation. Also, in July 1981 and February 1982, HCFA issued revised MMIS guidelines clarifying allowable MMIS costs.

OBJECTIVES, SCOPE, AND METHODOLOGY

The objectives of this review were to followup on HHS actions taken to implement prior GAO recommendations, including those taken to

--develop and apply MMIS performance standards and

--monitor State expenditures for MMIS.

Our review was conducted at HCFA central office in Baltimore; at HCFA regional offices in Chicago (Region V) and Kansas City (Region VII); and at State Medicaid Agencies in Kansas, Michigan, Nebraska, and Wisconsin. The two HCFA regions were selected because each had several States in their jurisdictions with an approved MMIS. The States were selected because (1) their approved MMIS had been operational for several years, (2) they provided a contrast between Medicaid agencies with entirely State operations (Michigan, Nebraska) and those using fiscal agents (Kansas, Wisconsin), and (3) reported MMIS operations costs ranged from relatively large ($18 million) to relatively small ($1.4 million). The review was conducted in accordance with the Comptroller General's current "Standards for Audit of Governmental Organizations, Programs, Activities, and Functions."

We evaluated the performance standards and related methodology used by HCFA in assessing MMIS performance in fiscal year 1981 and as revised for fiscal year 1982. Because the assessment system is new and HCFA is still refining it, our evaluation primarily consisted of determining whether the scope of the assessment was adequate. Due to the operational problems of the S/UR subsystem we noted in our prior review, our evaluation placed special emphasis on HCFA's assessment of that subsystem. We also examined HHS and HCFA regulations, guidelines, and other instructions pertaining to: (1) MMIS, including funding of improvements and operational costs, (2) financial and workload reporting, and (3) procurements of automatic data processing (ADP) equipment and services by State grantees.

Our review at HCFA headquarters included interviews of officials and a review of records and studies concerning: development of MMIS performance standards and assessment methodology; MMIS funding guidelines; revisions to the general systems design for the S/UR subsystem; and HCFA's oversight of State expenditures for Medicaid administration, including reporting requirements. Our review at HCFA regional offices included interviews of officials and review of records concerning: procedures followed and results achieved in assessing State's compliance with fiscal year 1981 MMIS performance standards; State Medicaid administration costs, including MMIS operations; and State proposals for projects to improve or maintain MMIS.

In all four States we interviewed officials and reviewed records regarding: operational features of MMIS; results of the fiscal year 1981 MMIS performance evaluation; surveillance and utilization review activity; Medicaid administration costs, including MMIS operations; and special projects to improve or maintain MMIS. In Kansas and Nebraska, our review of surveillance and utilization review activities also included determining the contributions of the S/UR subsystem, examining in detail its methodology, and testing whether certain conditions existed which could affect the accuracy of subsystem reports. These tests involved use of judgmental samples of physician providers. While these samples permitted us to determine whether certain conditions existed, statistically valid projections to the universe of physician providers in each State cannot be made.

Our recommendations are directed at the current Medicaid structure; however, recent Administration proposals could significantly affect that program in future years, if implemented. For example, the proposal to Federalize the Medicaid program would eliminate direct State responsibility for program administration and probably result in Federal contracts for claims processing services much like those provided by current Medicare intermediaries and carriers.

A second proposal would establish a capped, single payment to States for the administration of the Medicaid, Aid to Families with Dependent Children, and Food Stamp programs in lieu of the open-ended matching funds method currently authorized for each program.

We believe that such changes in the Medicaid program would not alter the basic premises used in formulating the recommendations in this report. For example, regardless of Medicaid's future administrative structure, there will be a continuing need to evaluate the adequacy of claims processing and surveillance and utilization review activities. In addition, there will be a continuing need to oversee, control, and accurately report claims processing system costs. As a result, we believe the objectives of our recommendations will have continued relevance.

We discussed our findings with officials of HCFA's central office, cognizant HCFA regional offices and the four States and obtained their comments which are reflected in this report where appropriate.

CHAPTER 2

NEED TO EXPAND MMIS PERFORMANCE EVALUATION

The Systems Performance Review--HCFA's program for evaluating MMIS performance--was first applied on a trial basis in 1981. The purpose of the program is to evaluate various aspects of MMIS operations and to identify MMIS operational problems. The results of the 1982 SPR will be used to assess financial penalties against States whose MMIS does not meet SPR standards.

While the SPR has been successful in identifying some program weakness, it does not, at present, evaluate several aspects of MMIS operation which would be valuable measures of MMIS performance. These include the economy of operation (a major purpose of MMIS), contributions of the S/UR subsystem toward identifying and correcting cases of program misutilization, and the adequacy of the S/UR subsystem exception processing methodology. Failure to evaluate these aspects of MMIS operations preclude HCFA from obtaining an accurate and complete assessment of MMIS performance.

MEASURE OF ECONOMY SHOULD BE ADDED TO THE PERFORMANCE EVALUATION

Even though the purpose of MMIS is to provide more efficient, economical, and effective administration of State Medicaid programs, the SPR currently measures only efficiency and effectiveness, such as claims processing timeliness and error rates. It does not include any measure of MMIS operational economy. As a result, HCFA cannot monitor the economy of a State's MMIS operations over time and cannot compare costs among State MMIS programs to identify and improve those that are not cost efficient.

In 1979, the MMIS Task Force also concluded that a measure of MMIS operational economy was needed. The Task Force recommended that an average cost per claim be computed for each State which could be used to compare its costs over time, and compare costs among States at a given time. The Task Force suggested that the average cost per claim be computed by using a "total MMIS cost approach"--i.e., dividing the total MMIS operating cost by the total claims processed during a given period. This result would then be adjusted for the appropriate variables (e.g., claims mix 1/).

HCFA currently evaluates the operational economy of Medicare claims processing agents through the use of cost per claim calculations. These costs are adjusted for variables, such as claims

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1/Claims for some types of providers, such as druggists, are generally easier to process than others, and this adjustment would compensate for differences in claims mix.

mix, claims volume, and wage rates. HCFA officials responsible for the SPR told us that the same methodology could be used in adjusting the average cost per claim in the Medicaid program. Furthermore, they indicated that reports which HCFA receives from States currently include the information needed to make such calculations. For example, States now submit monthly reports which show operational data, such as Medicaid claims mix and claims volume, and quarterly reports show MMIS operational costs. 1/

Because the SPR currently does not include any measurement of operational economy, HCFA cannot determine whether States' MMIS costs are reasonable. HCFA officials responsible for developing the SPR agreed that measurements of economy should be included; however, they indicated that inclusion of such measurements had been delayed in anticipation of a requirement that States implement a functional cost reporting system which would assure accurate and comparable cost data.

In our 1978 report we noted that HHS was not receiving relevant MMIS cost data and we recommended that the Department require States to report costs on a functional basis. We indicated that such information would help to determine whether MMIS operations are economical and assist States in identifying uneconomical practices.

A study report issued under a HCFA contract 2/ analyzed the costs of administering the Medicaid program and assessed the feasibility of requiring States to report costs on a functional basis. The study report indicated that, while States would incur varying degrees of startup problems, a functional cost reporting system was feasible. HCFA officials told us the agency has no current plans to require such a system because of the Administration's present emphasis on reducing State reporting requirements and more recent proposals to Federalize Medicaid.

Although measures of economy based on a functional cost reporting system would be preferable, such a system probably will not be available for at least several years. We believe that, in the interim, HCFA should include some type of operational economy measurements in the SPR, such as an average cost per claim, recommended originally by the MMIS Task Force in 1979.

1/Some adjustment to operational cost reporting requirements may be necessary since State costs as currently reported appear to be generally understated. (See p. 19.)

2/"Evaluation of Medicaid Administrative Costs," National Institute for Advanced Studies, June 10, 1980.

S/UR SUBSYSTEM CONTRIBUTIONS AND EXCEPTION PROCESSING METHODOLOGY ARE NOT EVALUATED

States are required to have a postpayment review process to identify and correct service misutilization by Medicaid participants (i.e., recipients and providers). The S/UR subsystem is a postpayment review process which is designed to assist States in meeting these objectives. The S/UR subsystem basic approach is the computerized exception processing technique. Under this technique, the computer applies criteria for excessive utilization of services to the claims histories of the total universe of providers and recipients in the Medicaid program and isolates and reports on those who exceed the criteria.

In our 1978 report, we stated that the S/UR subsystem was ineffective and underdeveloped--i.e., reports either were not being prepared or were prepared but not used and States were having problems in implementing the computerized exception process. The SPR standards for the S/UR subsystem include some requirements which should assure minimal use of that subsystem by the States. However, the SPR does not evaluate how effective the States' surveillance and utilization review activity was in identifying and correcting misutilization or the extent to which the S/UR subsystem contributed to that activity. Also, the SPR generally does not address the adequacy of each State's exception processing methodology.

Need to consider surveillance and utilization review accomplishments

States can generally meet most of the SPR requirements for the S/UR subsystem standard by investigating a minimum number of recipients and providers and demonstrating that the S/UR subsystem reports are used.

While all four States visited have had some success in identifying misutilization and taking corrective action, neither the adequacy of these accomplishments nor the S/UR subsystem contributions toward those accomplishments were measured under the SPR.

Since the end objective of surveillance and utilization review activity is to identify and correct misutilization, we believe the SPR should determine whether the number of corrective actions met certain predetermined expectations based on such factors as the State's Medicaid program expenditures and resources devoted to surveillance and utilization review. Furthermore, since enhanced Federal funding is provided to support the S/UR subsystem, we believe the SPR should also be addressing the contributions of that subsystem for identifying cases in which misutilization was established and corrective actions taken.

Identification and correction of misutilization

There are various means by which States can identify Medicaid program participants who may be misutilizing services. These include complaints from participants and the general public, referrals from State and Federal agencies, and reports generated by the S/UR subsystem. By using computerized exception techniques, the S/UR subsystem reports identify individual providers and recipients who may be misutilizing the Medicaid program. The appearance of providers and recipients on the S/UR subsystem exception reports does not prove program misuse, but does indicate the need to perform some investigation to prove or disprove misuse.

After establishing that misutilization has occurred, States must take corrective action. The MMIS general systems design recommends several types which include: (1) restricting recipients to preselected physicians and pharmacies in nonemergency situations (i.e., "lock-in"), (2) suspension or termination of providers from the Medicaid program, (3) recoupment of payments, (4) warning or educational letters to providers pointing out questionable medical or billing practices, (5) monitoring of claims for specific recipients or providers prior to payment, and (6) referral of cases for investigation of fraud or license violations. Other corrective actions, which are not recipient or provider specific, include establishing claims processing computer edits and closing "loopholes" in service coverage or payment policies.

Measures recommended by HHS study groups

The 1979 MMIS Task Force report concluded that State activity to control fraud, abuse, and waste was a key area of Medicaid program performance. It recommended that States be required to analyze these activities for such factors as cost of the activity, dollar value of recoveries, and cost/benefits. The report indicated that this type of information was needed for effective State program management and HCFA monitoring of State performance. The S/UR Advisory Panel also recommended that each State develop and use evaluative data to assess its S/UR subsystem, such as cost/benefits.

The Systems Technical Advisory Group, in making recommendations on MMIS performance evaluation, stated that some SPR standards must go beyond the scope of the automated information system. It also stated that efficient functioning of the subsystem can only be measured by evaluating actions taken in response to information generated by the subsystem. The Group recommended that standards in the SPR require that (1) a minimum number of providers and recipients appearing on S/UR subsystem exception reports be investigated, (2) investigations be documented, (3) States have mechanisms for various types of corrective actions, and (4) feedback

be obtained from S/UR subsystem customers on how the subsystem can better meet their needs. HCFA incorporated these suggestions in the SPR as well as a requirement that (1) those cases identified by the S/UR subsystem for investigation be adequately reviewed, (2) S/UR subsystem reports be prepared on time, and (3) S/UR subsystem reports be used for various purposes, which should include program evaluation and planning.

Use of S/UR subsystem in States visited

Nebraska was the only State of the four we visited which did not meet the 1981 SPR standard for the S/UR subsystem. 1/ It had few records to document surveillance and utilization review activity. Although the State had taken corrective action (e.g., "lock-in," recoupments) against some misutilizers, it was unable to demonstrate that it had reviewed the minimum number of providers and recipients identified through the S/UR subsystem exception process. Furthermore, those recipient cases which were reviewed were not completely investigated and there was lack of evidence that certain types of State S/UR subsystem reports were used. The SPR report also criticized Nebraska for failing to collect data, such as dollars recovered, and number and types of corrective actions taken as a result of S/UR subsystem profile analysis of recipients and providers. At the time of our visit, the State was initiating actions to assure that surveillance and utilization review activity was documented.

Kansas, Michigan, and Wisconsin met the 1981 SPR standards for the S/UR subsystem and had been successful in identifying cases of misutilization and taking corrective action. All three States have placed recipients on "lock-in" and have initiated recoupment actions against some providers. For example, during the first 9 months of 1981, Kansas initiated recoupment actions totaling about $447,000. During recent 12-month periods, Michigan and Wisconsin initiated recoupment actions totaling about $1 million and $900,000, respectively. In both States, some of these recoupments were due to coordinated efforts with outside agencies funded under section 17 of the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977 (Public Law 95-142), and some also resulted in court convictions of providers on felony charges. Other corrective actions taken by one or more of the States included suspension or termination of providers, issuance of warning and educational letters to providers, referral of providers for possible license violations, and recommendations for claims processing edits or changes in program policies.

1/Nationwide, seven States failed to meet this standard.

Records in Kansas indicated that about 77 percent of the recoupment cases discussed above and 63 percent of the 185 recipients on "lock-in" as of June 1981 were originally identified through the S/UR subsystem. Although we did not have time in our brief visits to Michigan and Wisconsin to analyze records to establish S/UR subsystem contributions in identifying cases of misutilization, officials in both States told us that S/UR subsystem contributions in identifying cases of misutilization were substantial.

Equitable standards are difficult to establish

HCFA officials stated that it would be desirable to include SPR measures of a State's accomplishments in identifying and correcting misutilization. They stated that, since inception of SPR development efforts, considerable discussion has been devoted to establishing criteria for measuring the success of surveillance and utilization review activities. To date, they have been unable to devise standards which would be equitable for all States. For example, they believe it would not be equitable to establish a standard that each State recoup a certain percentage of Medicaid program dollars each year because a State's prior efforts may have substantially reduced misutilization. A HCFA official did state, however, that consideration would be given to measuring the contribution of the S/UR subsystem to the States' overall accomplishments in identifying and correcting misutilization. This official stated it would be feasible under the Administration's paperwork/regulation reduction goal to measure S/UR subsystem contributions only if the required documentation did not significantly increase the State's recordkeeping burden.

Need to evaluate S/UR subsystem exception processing methodolgy

Computerized exception reporting substantially reduces human involvement in identifying potential misutilizers. Through this technique, the proportionately small number of potential misutilizers is isolated from other Medicaid participants with the speed and economy of computer processing. Three of the four States we visited in this review did not have an exception processing mechanism for developing a complete history of physicians' claims which, in turn, affected to some degree the accuracy of S/UR subsystem report data. This problem would not be identified through the SPR because exception processing methodology is not currently evaluated and only a cursory review is made of S/UR subsystem report accuracy.

Exception reporting technique

The general systems design for the S/UR subsystem specifies that exception reporting will be centered on the individual participant. That is, the system will summarize claims data for all

services provided to each Medicaid recipient and paid to each service provider. The exception process generally works as follows:

--Peer groups are established based on medical or demographic characteristics. For example, separate physician peer groups may be established for general practitioners, radiologists, etc. Recipient peer groups may be established based on age or sex.

--Indicators of misutilization are established for each peer group. Provider indicators may include such measures as dollars received or office visits per patient. Recipient indicators may include the number of different physicians seen or the number of prescriptions received for drugs with abuse potential.

--A statistical profile is developed using the peer group indicators and claims histories for all members of the peer group.

--A statistical profile is developed for each individual in the peer group, using the claims history for that member.

--The profile for each peer group member is compared to the peer group profile.

--Those individuals who deviate significantly from their peer group norm are reported as suspected misutilizers.

Although the SPR does not include any requirements for evaluating S/UR subsystem exception processing methodology, it does include a requirement that S/UR subsystem reports be complete, consistent, and contain no obviously invalid data. HCFA evaluators, however, are instructed to make this determination by scanning a sample of reports without verifying data contents.

Incomplete physician claims histories could affect S/UR subsystem data accuracy

In our 1978 report, we noted that some of the States were having problems implementing exception processing methodology, and the accuracy of data in their S/UR subsystem reports was questionable. Because of such historical problems, we reviewed certain aspects of S/UR subsystem exception processing methodology. Our review concentrated on physician providers because, nationally, they represent the noninstitutional class of providers receiving the most Medicaid funds and, in our opinion, represent the greatest challenge for exception processing methodology because of the variety of specialties and patterns of operation.

We determined how the four States visited dealt with two aspects of developing complete, integrated claims histories on individual physician providers for use in the exception processing cycle. These were

--development of complete claims history for individual physicians who provided specific services when the physician is a member of a group practice which bills and receives payment for services provided by its members and

--development of an integrated claims history for physicians having more than one identification number for billing purposes.

In order for each specific service to be charged to the claims history of the physician providing the service, the State must require the group practice to identify on the invoice the physician who provided each service billed. Inability to identify the individual provider in a group practice who performed each billed service means those services would be excluded from the individual providers claims history and would not be included in the individual's profile or in the computation of the applicable peer group norm.

The MMIS must also have a mechanism for consolidating a provider's claims history when that individual has more than one identification number. If an MMIS does not have that capability, individual providers who have more than one identification number will have more than one profile, each based on partial claims history. These partial claims histories may also affect the computation of applicable peer group norms where norms are based on ratios involving the number of physicians in the peer group.

Michigan and Wisconsin require group practices to identify, on billings, the individual physician providing each service shown on the invoice. Currently, Kansas and Nebraska allow group practices to have provider identification numbers and to bill for services without identifying the individual members providing them. During our review, Kansas was instituting a requirement that individual physicians be identified and Nebraska was considering such a change.

All four States allow, with some limitations, individual providers to have more than one personal identification number and to bill for services under each number. Michigan was the only State visited which had an MMIS mechanism to consolidate, for S/UR subsystem purposes, claims histories of physicians with multiple identification numbers. Wisconsin officials said they generally allow physicians to have more than one identification number if the physician practices more than one specialty or has offices in separate regions of the State. Kansas officials recognized the problem and were considering various solutions, such as

reducing the number of providers with multiple numbers. Nebraska officials believed the cost to do the required computer programming would outweigh the benefits derived.

The potential effect on exception processing methodology of the above problems would be to distort peer group norms and individual provider profiles. The actual effect on norms and profiles in those States having these problems could not be readily determined.

While the identity of individual physicians in Kansas and Nebraska providing services billed by group practices was not known, both States have numerous group practices enrolled and the amount of billings can be significant. For example, about 70 percent of the approximately 100 Nebraska physicians who received $20,000 or more from Medicaid in fiscal year 1981 were in group practices.

With regard to multiple identification numbers, discussions with State officials in the three States, which did not tie together physicians' claims histories and tests in Kansas and Nebraska, indicated that the number of physicians actually paid under more than one number may not be substantial.

Methodology requirements may be added to SPR

HCFA officials said they are currently considering various MMIS general systems design requirements not now reflected in the SPR for possible inclusion in the SPR for fiscal year 1983 or later. These deliberations have considered the need to assess the adequacy of the State's methods for developing basic data for MMIS subsystems, such as S/UR.

The HCFA officials stated that there could be some problems in requiring States to use specific methodology because the congressional intent of the 1980 amendments to the Social Security Act (section 1903(r)(6)(D)), 1/ indicates that the SPR should allow States flexibility in how they operate their MMIS. We believe that a State's methods of data development could be evaluated without specifying the exact methodology the States must use. Whatever methodology is used by a State should be evaluated to assure it produces accurate data.

1/See page S9726 of Congressional Record-Senate, July 24, 1980.

CONCLUSIONS

Since our report in 1978, HHS has developed system performance standards and related assessment methodology. However, under the present SPR, HCFA does not know whether States are meeting standards at a reasonable cost. HCFA has delayed adding a measure of economy of operation to the SPR in anticipation of a requirement that States implement a functional cost reporting system, which would help assure accurate and comparable data. Because of the importance of evaluating operational economy, we continue to believe as we did in 1978 that HCFA should require a standardized functional cost reporting system and evaluate that data as part of its SPR. Recognizing that full implementation of such a system may require considerable time and cost, we believe that HCFA should, as an interim step, include in its SPR an evaluation of operational economy, such as an appropriately calculated cost per claim.

The SPR standard for the S/UR subsystem appears to be effective in assuring that States make at least minimal use of the subsystem and document that usage. However, we believe that current SPR requirements for the S/UR subsystem do not adequately measure each State's effectiveness in identifying and correcting misutilization or assess the subsystem's contributions to those accomplishments. Such measures would require HCFA to establish standards for both overall surveillance and utilization review accomplishments and the S/UR subsystem contributions.

While HCFA has been unable to develop what it considers to be equitable standards for surveillance and utilization review accomplishments, we believe that certain measures could be added to the SPR at this time to address the S/UR subsystem contributions to the overall accomplishments. The States we visited had the basic information required to measure that subsystem's contributions and, in our opinion, any additional effort required of the States to summarize and analyze this information would be justified in that it would provide State managers with the type of data they should have to effectively manage the surveillance and utilization review activity.

While we were unable to determine the actual effect of the S/UR subsystem methodology problems on the accuracy of provider profiles and peer group norms, we believe they illustrate the need for HCFA to include some minimum requirements for the S/UR subsystem exception processing methodology in the SPR to assure a certain degree of accuracy in report data.

HCFA officials are considering adding some MMIS methodology requirements to future SPRs where it would not violate the legislative intent to allow States flexibility in how they operate their MMIS. We believe that a State's methods of data development could be evaluated without specifying the exact methodology the States must use. Whatever methodology is used by a State should be evaluated to assure it produces accurate data.

RECOMMENDATIONS TO THE SECRETARY OF HHS

We recommend that you direct the Administrator of HCFA to include in future SPR standards and methodology a requirement to measure

--operational economy,

--the State's effectiveness in identifying and correcting program misutilization,

--contributions of the S/UR subsystem to overall surveillance and utilization review accomplishments, and

--exception process methodology to better assure accuracy of S/UR subsystem data.

CHAPTER 3

FURTHER IMPROVEMENTS NEEDED IN HCFA'S OVERSIGHT OF STATE EXPENDITURES FOR MMIS OPERATIONS

HHS has taken recent actions to increase its oversight of State expenditures for MMIS operations. States are now required to identify separately, on cost reports, those expenditures attributable to MMIS operations, which was not required at the time of our 1978 report. A departmental regulation also requires States to seek prior approval or give notice prior to planned procurements of ADP equipment or services exceeding certain dollar thresholds, regardless of the percentage of Federal funding.

While these actions should strengthen Federal oversight, deficiencies in HCFA guidelines are resulting in States (1) understating MMIS operations costs and (2) procuring ADP equipment and services without obtaining prior approval or giving prior notice as required in HHS regulations. As a result, reported MMIS operating costs do not have the degree of accuracy needed to evaluate State performance and HHS' central office has been denied the opportunity to consider in advance the merits of some ADP equipment acquisitions and projects funded at the 75-percent Federal rate.

MMIS OPERATING COSTS ARE UNDERSTATED

We found that MMIS operating costs in the States visited were understated, primarily because the cost of certain personnel were not allocated to MMIS--i.e., the cost of MMIS functions which were performed by skilled professional medical personnel were not allocated to the MMIS cost center. As a result, total MMIS costs reported by these States were understated. This would affect the calculation of an accurate MMIS unit cost for use in assessing operational economy as part of the SPR. (See p. 8.) Without such data, comparisons of system operational economy by a given State over several years or among States in 1 year cannot be made.

Skilled professional medical personnel are used in various aspects of the Medicaid program, such as inspecting nursing homes, assisting in administrative decisions which require a medical background, and assisting with MMIS functions, such as performing initial analysis of recipients and providers who may be misutilizing the Medicaid program. To encourage States to retain and use skilled medical professionals in administering the Medicaid program, the Social Security Act authorized 75-percent Federal funding for skilled medical personnel costs rather than the normal 50-percent funding rate.

Current HCFA instructions on the reporting of skilled professional medical personnel costs are not clear as to how such costs for personnel assigned to MMIS duties are to be reported. Because the level of Federal funding is the same for skilled professional medical personnel and MMIS operations, the States we visited generally reported one total figure for all skilled professional medical personnel, rather than allocating the appropriate portion to the reported cost of the MMIS. As a result, these States understated total MMIS costs.

Medicaid cost reports now identify MMIS operating costs

In our September 1978 report, we stated that HCFA did not know the total cost of State MMIS operations because costs with the same Federal funding rates were combined on HCFA's Medicaid cost reimbursement form. For example, MMIS operations and skilled professional medical personnel costs, both federally funded at 75 percent, were combined into one figure on the same line of the report.

In October 1978 HCFA issued a new form and guidelines for States to use in claiming Federal funding for the cost of Medicaid administration. 1/ The form contains separate lines for reporting the various types of Medicaid administration costs, such as MMIS operations and skilled professional medical personnel.

MMIS operating costs understated in States visited

Using HCFA guidelines, 2/ we reviewed the new expenditure forms and supporting documents for the four States we visited to determine whether reported MMIS operating costs appeared reasonable and accurate. As shown by the table on the following page, we found MMIS operating costs to be understated.

1/HCFA Action Transmittal 78-95, dated October 30, 1978, transmitted the guidelines for preparation of the HCFA-64.10 "Statement of Expenditures for State and Local Administration and Training for the Medical Assistance Program" which superseded SRS-OA-41.10 "Statement of Expenditures for State and Local Administration and Training for the Medical Assistance Program."

2/Program Regulation Guide No. 31 (PRG-31), dated June 1974 and supplements, and Part 11 of State Medicaid Manual, dated July 1981, which replaced PRG-31.

State	Reported MMIS cost FY 1981	Estimated amount MMIS understated	Percent understated
Nebraska	$ 2,100,000	$169,000	8
Wisconsin	13,700,000	240,000	2
Michigan	18,000,000	(a)	(a)
Kansas	1,400,000	282,000	20

a/Michigan reported costs of $7.9 million for skilled professional medical personnel in fiscal year 1981. Officials are currently reviewing the duties of these personnel to identify those which perform MMIS functions, however, at the time of our review, no estimate of the MMIS operating cost understatement was available. (See below.)

Personnel costs not allocated to MMIS operating costs

In all four States reviewed, MMIS costs were understated. In three States, this resulted because the costs of skilled professional medical personnel assigned MMIS duties were not allocated to MMIS. (MMIS costs were understated in Kansas for another reason. See p. 22.) The skilled professional medical personnel in those States were involved in (1) the initial analysis of recipients or providers identified on S/UR subsystem exception reports and/or (2) approval of services before delivery or review of delivered services before payment. Nebraska and Michigan reported personnel involved in both MMIS functions as skilled professional medical personnel costs, rather than as MMIS operating costs. Wisconsin reported the cost of personnel engaged in S/UR subsystem initial analysis as skilled professional medical personnel costs, while the cost of personnel performing the second function was reported as MMIS operations. Nebraska officials said that reporting such costs totally in the skilled professional medical category eliminates the need for an allocation method to determine that portion of each professional's time attributable to MMIS operations.

Michigan is reviewing the functions of all personnel currently reported as skilled professional medical to identify those who should more properly be classified as being involved in MMIS operations. In fiscal year 1981 Michigan reported skilled professional medical costs of $7.9 million. Although the results of their study have not been finalized, officials believe that about 60 percent of the personnel classified as skilled professional medical in 1981 performed MMIS functions and will be reported as MMIS operations costs in the future.

Medicaid administration and training cost reporting instructions are silent as to how costs of skilled professional medical personnel assigned MMIS duties are to be reported. HCFA officials who prepared the guidelines were unaware of this reporting problem

but agreed that it has significance. They said the situation would be discussed at an upcoming meeting of the HCFA regional officials who review and certify State administrative costs.

Confusion as to allowable MMIS operating costs

Kansas' MMIS cost was also understated but for a different reason. Kansas officials reported their cost of MMIS surveillance and utilization review, which was performed by a contractor, as general administration costs rather than MMIS cost because HCFA Region VII officials had ruled that surveillance and utilization review beyond the point of generating S/UR subsystem reports was not considered MMIS operations and, therefore, ineligible for 75-percent Federal funding. HCFA regional officials also ruled that 75-percent funding for skilled professional medical personnel was limited to State employees, and therefore, the cost of these contractor personnel did not qualify for the enhanced funding. As a result, Kansas received only 50-percent Federal funding for its MMIS surveillance and utilization review costs.

The regional office "non-MMIS" ruling was made before the issuance of the State Medicaid Manual in July 1981 which provides that analysis of S/UR subsystem exception reports is considered MMIS operations. Regional office officials told us that the Kansas ruling is being reconsidered in light of the new guidance.

We found that the instructions in the new manual, which have caused HCFA regional officials to reconsider their earlier ruling, were actually added to HCFA guidance in 1977. 1/ Region VII officials were unaware of the 1977 change and central office officials stated that it may not have received wide distribution. Based on both the 1977 and 1981 guidance, it appears that the costs in question in Kansas were attributable to MMIS operations, and therefore, MMIS operations costs were understated.

NEED TO ENFORCE REGULATIONS REGARDING PURCHASE OF ADP EQUIPMENT AND SERVICES

HCFA has not always enforced the requirement in HHS regulations that States obtain prior approval or give prior notice on certain MMIS acquisitions of ADP equipment and services which exceed specified dollar thresholds. While HCFA's State Medicaid Manual establishes similar requirements for acquisitions made at 90-percent Federal funding, it does not do so at the 75-percent Federal level applicable to MMIS operations. As a result, States have made sizable ADP equipment or service acquisitions at the latter Federal rate without the benefits of HCFA central office review.

1/Program Regulations Guide (PRG-31) dated May 1974 was updated by Action Transmittal 77-75 dated July 7, 1977.

Recognizing a need for more effective control over the Federal financial support of State systems, HHS revised its regulation (45 CFR Part 95) in 1978 governing the purchase of ADP equipment and services by State grantees, including State Medicaid agencies, to make approval requirements more specific. That regulation, as amended further in 1980, requires that States obtain prior HHS approval when purchasing ADP equipment and services that cost $100,000 or more over a 12-month period, or $200,000 or more for the total acquisition. The regulation also requires States to notify HHS 60 days before acquisitions of ADP equipment and services that cost between $25,000 and $100,000 over a 12-month period. 1/

States must obtain prior approval by submitting an advance planning document to the HHS Assistant Secretary for Management and Budget who establishes control and forwards it to the appropriate HHS operating component for review. The advance planning document is the States' written plan for acquiring the ADP equipment or service and includes (1) a statement of needs and objectives, (2) a preliminary cost/benefit analysis, (3) a personnel resource statement indicating availability of qualified and adequate staff, (4) a detailed description of the nature and scope of activities to be undertaken, (5) a proposed budget, and (6) a statement indicating the period of time the State expects to use the ADP equipment or services.

Prior notifications are also sent to the HHS Assistant Secretary of Management and Budget. The notification states (1) the need the acquisition will satisfy, (2) the nature and scope of the acquisition, (3) alternatives to the acquisition, and (4) total cost of the acquisition. The primary purpose of the prior notification requirement is to keep States from proceeding with an acquisition which may be inadvisable for reasons unknown to the State, such as recent policy changes.

Specific instructions to States for obtaining enhanced MMIS funding are contained in HCFA's State Medicaid Manual, Part 11. The manual requires that States obtain prior HCFA approval in order to receive 90-percent funding for the design, development, and/or installation of an MMIS as well as for subsequent MMIS improvements. The prior approval process is the same as that required by HHS regulations, except that all proposed projects to be funded at 90 percent must include an advance planning document regardless of cost.

1/Before February 1980, the prior approval was required for acquisitions over $25,000 and there was no prior notification requirement. This change was made to reduce the paperwork burden on both the States and HHS.

Sections of the manual which cover projects eligible for 75-percent funding, however, deal with matters other than prior approval, such as the process for obtaining system approval and the identification of MMIS operating costs. The manual does not (1) require prior HCFA approval or notifications for projects to be funded at the 75-percent rate or (2) make a direct reference to the applicability of the HHS regulations. As a result, States have, under the manual, made sizable ADP equipment and service acquisitions and obtained 75-percent Federal funding without following the HHS regulation.

HCFA central office review of projects

HCFA's Office of Methods and Systems is responsible for reviewing all prior approval requests and prior notifications involving Medicaid funds. The office's system analysts assist States in improving planned projects and provide HCFA with control over expenditures. Each advance planning document for an MMIS purchase is reviewed with emphasis on how the proposal will benefit the system's operations, the costs/benefits of the proposal, and its qualification for Medicaid funding.

Office reviews have identified less costly or more efficient alternatives to State plans and have identified proposals that seek a higher level of funding than justified. The following examples demonstrate some past benefits of central office review.

--HCFA's review of Michigan's advance planning document for 90-percent funding to convert the MMIS reference subsystem to more current medical diagnosis codes (ICD-9-CM) indicated the estimated staff-hours for this project was considerably higher than what was required for similar conversions in other States. A central office site visit resulted in the estimates being revised downward from $1,096,785 to $941,777.

--In September 1981, HCFA's review of Missouri's advance planning document for the in-house development of an automated cost allocation plan raised several concerns. Reviewers pointed out that a number of excellent, reasonably priced job accounting packages were already on the market, and that cost allocation and job accounting are administrative, not MMIS functions, and thus can be funded only at the 50-percent level. Missouri had requested 75-percent Federal funding.

Some projects did not receive HCFA central office review

Three of the four States we visited had received 90-percent Federal funding for the design, development, and/or implementation of the original MMIS or subsequent improvements. All three States

had submitted advance planning documents and obtained prior approval in accordance with the HHS regulation and HCFA Manual. However, we found that Wisconsin and Kansas had also received 75-percent Federal funding for the acquisition of ADP services to modify or maintain their MMISs without submitting an advance planning document to the central office even though the acquisitions exceeded the dollar threshold established by the HHS regulation.

In 1979, the Wisconsin State Medicaid Agency paid its fiscal agent approximately $250,000 to convert the MMIS reference file subsystem to newer medical procedure and diagnosis codes (CPT-4 and ICD-9-CM). This cost was in addition to the cost of services covered by the fiscal agent contract. Officials at the State Medicaid Agency and HCFA regional office said the project was considered system maintenance and, therefore, did not require prior approval in order to receive 75-percent Federal funding. An official from the HHS' Office of the Assistant Secretary of Management and Budget agreed that HCFA's State Medicaid Manual did not require prior approval of this project; however, he said the acquisition exceeded the thresholds established by the HHS regulations and the State should have obtained prior approval before receiving Federal funding.

The Kansas State Medicaid Agency paid its fiscal agent about $133,000 in 1981 to implement and operate a computerized early and periodic screening, diagnostic, and treatment tracking system that had been designed and developed by another contractor. The Federal Government funded 75 percent of the costs. A HCFA regional office official said he did not require the State to submit an advance planning document because the State Medicaid Manual did not establish prior approval requirements for 75-percent Federal funding projects. The official said that failure to require an advance planning document was not a conscious effort to avoid the provisions of the HHS regulations, but he agreed that in retrospect an advance planning document was probably required.

Officials in Nebraska and Michigan said they plan acquisitions of additional ADP services in 1982 which will exceed $25,000. They said the projects would probably be classified as maintenance and, in accordance with the provisions of the State Medicaid Manual, they did not plan to seek prior approval or give prior notice. While some of these projects might be eligible for 90-percent funding if classified as improvements, officials in both States said that the decisions to classify the projects as maintenance and accept 75-percent funding was influenced by the fact that the cost of preparing an advance planning document might exceed the extra funds obtained from the 15-percent differential.

CONCLUSIONS

HCFA needs accurate MMIS cost data to effectively carry out its monitoring role. Recent changes in reporting Medicaid administrative costs have increased the specificity of reported costs, including MMIS operations. However, the lack of guidance, about where the costs of personnel eligible for 75-percent funding under both MMIS and skilled professional medical personnel provisions of the Social Security Act should be reported, caused States to underreport MMIS operation cost. Underreporting of MMIS operations costs reduces the accuracy of this source for use in the SPR to measure the operational economy of MMIS.

We believe that HHS regulations requiring States to obtain prior approval or give prior notice on certain acquisitions of ADP equipment and services provide valuable oversight and control over Federal expenditures. The lack of such requirements in the State Medicaid Manual for acquisitions at the 75-percent level has resulted in States proceeding with sizable acquisitions of ADP equipment and services without central office review. HCFA, therefore, has no assurance the projects were needed, cost effective, or eligible for enhanced MMIS funding.

RECOMMENDATIONS TO THE SECRETARY OF HHS

We recommend that you direct the Administrator of HCFA to

--clarify instructions to the States for reporting Medicaid administrative costs to assure that costs of personnel who may qualify as skilled professional medical personnel but are engaged in MMIS functions be reported as MMIS operations costs and

--revise the State Medicaid Manual so that it is consistent with the HHS regulation which requires prior approval or advance notice of ADP equipment and services purchases.

STATUS OF MMIS PROGRAM IN MEDICAID JURISDICTIONS (note a)

MARCH 1982

Jurisdictions with approved system	Dates of initial approval determination	Effective date for 75-percent rate (note b)
Alabama	08/01/78	04/01/78
Arkansas	04/06/76	01/01/76
California	11/29/78	01/01/78
Colorado	07/10/80	10/01/79
Florida	08/08/79	10/01/78
Georgia	11/07/77	08/01/77
Hawaii	various	01/01/73
Idaho	08/08/78	01/01/78
Iowa	07/15/80	10/01/79
Indiana	01/25/77	01/01/76
Kansas	03/27/79	07/01/78
Louisiana (note c)	05/22/78	07/01/77
Maine	02/18/81	07/01/80
Michigan	03/25/76	01/01/76
Minnesota	11/03/75	07/01/75
Mississippi	09/24/80	07/01/79
Missouri	04/04/80	08/01/79
Montana (note c)	06/07/77	11/01/74
Nebraska	11/08/78	07/01/78
New Hampshire	09/18/75	07/01/75
New Jersey	09/28/79	04/01/79
New Mexico	05/29/75	06/01/73
New York (5 regions)	various	10/01/79
North Carolina	05/15/78	07/01/77
North Dakota	08/28/79	09/01/78
Ohio	05/13/76	10/01/75
Oklahoma	04/26/77	01/01/73
Pennsylvania	12/23/81	07/01/81
South Carolina	06/26/81	03/01/81
Tennessee (note c)	09/24/80	12/01/79
Texas	04/22/76	06/01/75
Utah	12/15/75	10/01/75
Vermont (note c)	04/04/79	04/01/78
Virginia	11/09/78	12/01/77
Washington	10/29/76	07/01/76
West Virginia	11/02/81	10/01/80
Wisconsin	02/01/78	10/01/77

a/Excludes Arizona, which does not have a Medicaid program.

b/HCFA generally requires a system to be in operation for about 6 months before it conducts an approval review. The approval is made retroactive to the month the system was deemed to be fully operational.

c/States are operating new systems which have not yet been approved by HCFA.

Jurisdictions with operational systems not yet approved by HCFA

District of Columbia
New York (4 regions)
Illinois
South Dakota

Jurisdictions planning, designing, developing, or installing MMIS

Connecticut
Kentucky
Massachusetts
Nevada
Oregon

Jurisdictions with no active Federal MMIS plan

States:
- Alaska
- Delaware
- Maryland
- Rhode Island
- Wyoming

Territories:
- Guam
- Northern Mariana Islands
- Puerto Rico
- Virgin Islands

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