# MEDICAID QUALITY CONTROL PILOT PROGRAM

## STATE MEQC PILOT PROJECTS

**Update Number 2 (September, 2000)**

The following States furnished updated project material for inclusion in the HCFA Medicaid Quality Control Pilot Program website.

## ALASKA

**PROJECT:** DENALI KID CARE (CHIP) AND INSURANCE REQUIREMENTS

### DESCRIPTION:

In Alaska, we implemented our SCHIP program through a Medicaid expansion called Denali KidCare. When this MEQC pilot began, Denali KidCare had been in existence long enough that all recipients initially enrolled had now gone through the six month renewal cycle.

#### Purpose:

This short-term project was to assess how effective our streamlined eligibility processes were and to address concerns about crowd-out. When considering continued funding for Denali KidCare, the state Legislature wanted assurance that the program was not being used to replace existing private health insurance. This pilot project would provide data the Medicaid agency could use to defend continued funding. Consequently, we focused on why children were or were not retaining eligibility and to what extent having or losing private health insurance affected that eligibility.

#### Design:

Four months were sampled. QC staff did not do a full redetermination of eligibility, but used a limited review that allowed them to increase the sample size. In their review, they focused on how many children:

- retained eligibility;
- lost eligibility because their income exceeded 150% FPG and they had insurance;
- lost eligibility because their income exceeded 200 % FPG;
- lost eligibility because of a change in household size;
- lost eligibility for other reasons.

Using the same case sample, the QC staff looked at how accurate caseworkers had been at verifying existing insurance coverage at the time of initial application. They were also asked to look for indications of people dropping insurance in order to qualify for Denali KidCare.

**Results:**

Only one of 130 case reviewed was found to have dropped private health insurance before applying for Denali KidCare. Only nine percent of the sample actually had private health insurance available at the time of application. Of those that did have insurance, 88% had never enroll because they could not afford it. Within the scope of this project, crowd-out was not found to be a problem in Alaska.

**Future Projects:**

Our next MEQC project will take a more comprehensive look at the accuracy of Denali KidCare eligibility determinations. In addition, we are going to try to identify the number of children each month that would have lost Denali KidCare if not for the protection of our 6-month continuous eligibility policy for children. We are also looking at verification requirements to see if some eligibility factors warrant more or less verification. We will continue to track the reasons recipients lose eligibility just as we did in the previous project.

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## ARIZONA

Arizona has operated under an MEQC pilot since April 1994. The pilot has focused on the Arizona Long Term Care Program because of the expense of this program. Two initiatives to reduce error/deficiency rates in this program are now completing their first year of operation.

The **Operation Recall** Project, AKA CARE (Client Awareness Reduces Errors), was begun as a pilot in the Glendale local office in 8/99. Under this pilot, all initial approvals for the Long Term Care Program (Medicare Cost-Sharing cases were included at a later date) were selected for follow-up 90 days after approval. One person in the local office, whose job it was to contact the authorized representative or recipient, followed up and reviewed elements of the application. This phone call follow-up starts with a customer service survey regarding client treatment by eligibility staff, local office processes, etc., and then goes into a review of the elements of eligibility. Based on a recent report, 61% of the phone calls made on LTC cases revealed information not previously known to the eligibility office. This information included information not previously revealed at the initial interview as well as changes that had occurred since the case was approved for benefits. For Medicare Cost sharing clients the percentage of new information received was approximately 25%.

The Glendale office has already seen a decrease in the case error/deficiency rate, and expects to see the full impact of this initiative with the release of their 4/00-9/00 case error rates.

The second initiative - **Regional Corrective Action teams** – was implemented in September 1999 with a two-day training in the corrective action process. Nine teams, each representing a metropolitan office or a region, received a two day Corrective Action training which taught them to analyze errors and deficiencies, identify root causes, brainstorm effective corrective actions as well as how to sell, implement and monitor their corrective action initiatives. Each team was expected to produce a corrective action plan by March 2000. Corrective Actions which could be implemented at the local level were implemented immediately. Initiatives which required administrative approval or assistance were reviewed by a statewide Corrective Action team which then established statewide trends and used the suggestions submitted by the regional teams for statewide corrective action when appropriate. This effort to bring the corrective action process to the grass roots level has helped local office staff to become more aware of the error trends and has helped to insure the buy-in of staff who must implement the changes. At the end of each review period new reports will be issued to the teams and new plans will be written as needed. Since most corrective actions were not implemented until 3/00, the impact of this corrective action will not be fully evident until the 4/01-9/01 review period.

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**CALIFORNIA**

**PROJECT: CALIFORNIA GEOGRAPHICAL SAMPLING PLAN (GSP) PILOT PROJECT**

**DESCRIPTION:**

**Goals:**

- Enhance travel efficiency and eliminate unnecessary home visits.
- Provide more data in order to better evaluate the Medicaid program.
- Work more closely with the 58 counties in California on Medicaid issues.

**Accomplishments:**

- Greater travel efficiency due to the elimination of the 35 smallest counties in terms of the number of Medicaid beneficiaries from the ongoing MEQC sample. As practically all of the MEQC cases selected for review in the 23 large counties are now within close proximity of a Program Review Section (PRS) office, overnight travel for MEQC reviews has been reduced to a minimum.

- Due to the GSP Pilot Project, the number of annual MEQC case reviews has increased 33 per cent and are now distributed among the largest 23 counties instead of all 58 counties in California. The increased number of MEQC case reviews in each

large county has resulted in more reliable data concerning error trends. PRS has initiated Focused Reviews (FR) on counties with a high MEQC error rate or on specific Medicaid program areas. The FR program allows PRS to work cooperatively with the counties on corrective action.

- To provide data on the 35 small counties which are not part of the ongoing MEQC sample, PRS has developed a Periodic Case Review (PCR) program which reviews at least ten Medicaid cases for one sample month in each of the 35 small counties. The intent of the PCR is to provide the state and small counties with a management information tool. Prior to the implementation of the GSP Pilot Project, several of the small counties had as few as one or two MEQC cases annually.

- As part of the effort to become more efficient, a home visit matrix was developed to indicate those cases that had a high possibility of error and would require a home visit (e.g. cases with high fluctuating earned income, cases with unreported assets, etc.). Cases with a low possibility of error would not require home visits. The implementation of the Home Visit Flexibility Policy for MEQC case reviews resulted in a reduction in the number of home visits from 90 percent of all cases in the MEQC sample to approximately 40 percent currently.

- As part of the GSP Pilot Project, PRS increased the MEQC dollar error threshold from $5 to $50 effective with the April 1999 MEQC sample month. As the cost of medical care has increased dramatically in the last twenty years, PRS believes that the increase to $50, before an error is cited, is very reasonable. By citing only errors of $50 or more, MEQC error analysis can focus on the major error trends found in the MEQC reviews. PRS still notifies the counties of the discrepancies which are less than $50. PRS conducts Corrective Action Follow-Up reviews of all discrepancies and errors found during a six-month base period to ensure that they have been corrected. (California is increasing the dollar error threshold from $50 to $100 effective with the April 2000 MEQC sample. In an analysis of MEQC data, 92 percent of all dollars identified as erroneous involved cases with an error amount of at least $100).

- As there is concern that erroneous Medicaid denials and discontinuances may be contributing to the decline in Medicaid enrollment nationally, PRS has increased its effort in this area because of the efficiencies made possible by the GSP Pilot Project . Of the 553 total Negative Case Action (NCA) reviews completed in fiscal year 1999/2000, only nine (1.63 percent) had citeable errors. In fact, PRS found that several counties had a 100 percent accuracy rate for the NCA reviews.

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## COLORADO

**PROJECT: LONG TERM CARE ELIGIBILITY FOR SPOUSAL PROTECTION CASES**

**Purpose:**

To evaluate Medicaid application processing and eligibility determination for long-term care cases involving community spouses. Medicaid Eligibility Quality Control (MEQC) evaluated statewide accuracy and timeliness in determining eligibility, patient payment, and third-party medical resources for these spousal-protection cases.

**Sample:**

Random statewide samples that were selected from a monthly report of nursing-facility clients who also had spouses living in the community.

**Summary of Findings:**

In 34% of the reviewed cases, the transfer of resources to the community spouse had not taken place within 90 days of approval. If that issue were excluded, 92% of the cases were resource-eligible. Miscalculations of the patient payment existed in 24% of the resource-eligible cases, however. Findings, now completed for 111 case studies, have been updated to executive managers in monthly reports and to counties via regional training by state program managers and by a departmental newsletter.

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## DISTRICT OF COLUMBIA

**Medicaid Pilot Project-Phase I (C) (R 2/1/97 – 17 month project).**

- An analysis of client eligibility/error proneness of LTC cases for skilled, intermediate and ICF\MR.
- Tested methods for identifying eligibility errors related to failure to report resources and/or assets and violations in policy relative to the transfer of assets or resources.
- Focused on 4 groups: most costly by program code; most costly LTC facilities; conservators; cases with deceased clients.
- 529 cases were reviewed.

**Medicaid Pilot Project-Phase II (C) (R 6/30/98 – 12 months study).**

- An outcome based analysis of the accessibility of medical care for TANF managed care customers.
- An analysis of additional error prone LTC cases that supports cost containment strategies.
- A resolution to Medicaid Management Information Systems interface issues.
- An analysis of program expenditures for TANF and LTC customers.
- Main focus was to conduct a TANF survey of enrollees in managed care program on the accessibility to medical care; and conduct a second review of LTC customers.
- 522 customers were surveyed.

**Medicaid Pilot Project-Phase III (CEP, ER) (R 12/99-18 month project).**

- Purpose is to determine if the Managed Care program is meeting the needs of the TANF customers by: evaluating the accessibility and satisfaction of care; determining if providers are meeting the Managed Care program requirements; conducting a Client and Physician Survey; and determining if the error rate is affected by the implementation of Managed Care.
- 750 customers were surveyed.

**Medicaid Pilot Project-Phase IV (12 month project).**

- The purpose is to identify dual eligibles and potential enrollees for the Medicare and/or the Qualified Medicare Beneficiary Low-Income Medicare Beneficiaries/Qualifying Individuals programs for the District of Columbia.
- To suggest strategies and recommendations to eliminate barriers of eligible/dual eligible individuals and to measure the impact of reducing barriers to enrollment.
- To evaluate means to promote the Medicare buy-in program with special emphasis on the elderly and individuals with disabling conditions.
- D.C. proposes to survey 405 individual.

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## FLORIDA

**PROJECT: IDENTIFICATION OF MEDICARE BENEFICIARIES IN THE MEDICAID PROGRAM**

**DESCRIPTION:**

To evaluate current files and processes, make necessary corrections to the current files, to accomplish buy-in of individual recipients and make needed adjustments to processes and systems.

**Plan:**

Review Medically Needy aged and disabled persons to assure that their Medicare status has been properly identified, that the proper paperwork is complete to enroll them in QMB or SLMB and that buy-in has occurred if they are eligible for QMB or SLMB.

Examine Medicaid eligible persons who are aged and disabled to assure that their Medicare status is properly identified in the eligibility file, to determine if buy-in has occurred, to assure that persons with income below 100 % of the federal poverty level are enrolled in QMB, as well as full Medicaid.

Review buy-in file output error reports, take corrective actions on the individual cases, and to assess training, system enhancements and procedures needed to prevent errors.

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## IDAHO

### PROJECT: ACCESS TO CHILDREN'S HEALTH INSURANCE PROGRAMS

**Purpose:**

This project evaluates the accuracy rates of approvals and denials for Children's Health Insurance Program (CHIP) and other Medicaid programs for children. In October 1999, Idaho made significant changes to improve access to CHIP and other Medicaid programs serving children. These changes included a much shorter four-page application form, self-declaration of income and assets, mail-in applications and 12 months continuous eligibility. This project measures the accuracy rate since these changes were implemented.

**Design:**

Each month, the Program Evaluation team reviews a statewide random sample of approximately 100 approval and denial actions. This number assures that over a twelve-month period, the margin of error is ± 5% with a 95% confidence level. Findings are reported monthly and are used in our quality improvement efforts to increase access to services.

**Findings:**

The Program Evaluation team reviewed 289 approval and 300 denial actions taken between November 1999 and April 2000. Cumulative findings in the latest quarter (February through April 2000) are an 86% accuracy rate for denials and a 100% accuracy rate for approvals. The approval accuracy rate has remained very high each month. The

denial accuracy rate has shown a steady improvement from a 71% accuracy rate for November 1999 to 91% for April 2000.

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## ILLINOIS

### PROJECT: RECIPIENT SERVICES VERIFICATION PROJECT (RSVP) I (TRANSPORTATION & PHYSICIANS)

**DESCRIPTION:**

**Purpose:**

This project was designed to determine if physician and transportation services billed to the Department of Public Aid (DPA) were actually received by the recipient.

**Design:**

Cases were selected from the universe of all cases with physician or transportation services in twelve counties. These twelve counties were located in the central area of Illinois and were chosen due to their proximity to the available staff. Therefore, this pilot is not statistically valid, but may indicate the kinds of problems one might find if the sample was randomly selected statewide. Paid claims were identified in the Medicaid Management Information Service (MMIS) database with dates of service (DOS) between June 1, 1997 through October 19, 1997.

**Review Protocol:**

Cases were completed utilizing either a face to face interview or telephone interview with the client, or an interview with another source (such as a caregiver) considered reliable by the reviewer. The BMI reviewers did not contact the providers. Clients were queried about whether or not they received the medical service billed to DPA. Three categories of responses were possible; "yes" the service was received, "no" the service was not received, and "not sure" the client was uncertain as to whether they received the service or not. Additional comments from recipients, regardless of whether or not the service was received were recorded and reviewed. Cases containing negative responses (no and not sure) were further investigated to establish whether services were actually received.

Transportation claims were matched against a date of service for either a physician, hospital inpatient or outpatient, or some other claim type that would justify the transportation service. To determine if transportation services were being over utilized, we looked at the number of transportation services per case. We also looked at the type of transportation used (emergency vs. non-emergency) and compared it to the diagnosis

code(s).  For example, was an ambulance used to transport the recipient to the hospital for a migraine?

**Results:**

Only 2% (all physician claims) of the 1348 cases reviewed indicated the recipient did not receive the service.

A total of 1605 cases were processed; 1348 were completed and 257 cases (all physicians) were dropped. Cases were dropped for several reasons: services were supplied by a provider that the recipient would not necessarily have been in contact with, for example, pathologists, lab technicians, hematologists, etc. (69); group care (18); out-of-state (10); non-cooperating (0); couldn't locate (156); deceased (2); and other (2).

Of the 1348 cases reviewed, the majority were physician claims (97%) and the remaining cases (3%) were transportation claims. There were a total of 168 negative responses, with 136 (125 physician, 11- transportation) containing "not sure" responses and 32 (all physician) containing "no" responses.  Further analysis of the negative response (no and not sure) cases prompted the referral of 21 physician cases (all no responses) to the Narrative Review Committee for possible audit or peer review.

**PROJECT: RMEC PILOT (RETURN MEDICAL ELIGIBILITY CARD).**

**DESCRIPTION:**

**Purpose:**

Medical Eligibility Cards (MECs) are mailed to clients monthly.  Medicaid providers view these cards in order to verify client's eligibility for Medicaid services.  Large numbers of cards are returned to the Department of Public Aid (DPA) as undeliverable each month.  This project was a pilot to see if a pattern emerged from examining a small group of returned cards.  The results did not reveal a pattern at which to direct improvement.  However, a  larger resolution is in process.   In fiscal 2001, DPA will be switching to permanent plastic cards that clients will retain to show to providers to verify their eligibility for Medicaid services.

**Design:**

This project was completed in September 1998, with a total of 36 cases selected for review.  The cases were chosen from downstate counties based on availability of resources.  Because so few cases were selected and it was not a random sample, it would be incorrect to attempt to project these findings on the total universe of cases with returned MECs.

**Review Protocol:**

Cases were completed utilizing either a face-to-face interview or telephone interview with the client, or an interview with another source (such as a caregiver) considered reliable by the reviewer. Interviews were completed on approximately one-half of the cases. The BMI reviewers did not contact the Medicaid providers.

**Results:**

Client Error:

- 25% - In nine of the cases, client error caused the returns. Either the client moved and failed to report their move or they reported an incomplete or incorrect address.

Agency Error:

- 22% - In eight of the cases, the client reported the address change correctly but it was too late to effect the change before the MEC was mailed. Changes must be entered into the system before a certain date each month in order to be effective for the next month.
- 14% - In five of the cases, the MEC was returned due to local office action or inaction. These five included one in which the new address was reported but no action was taken, one in which a new address which was reported correctly was entered incorrectly, and three in which the new address was entered in a companion case but not for the case under review.

Other Reasons:

- 6% - The MEC was returned in two cases solely due to Post Office error.
- 3% - One case did not fall into any of the established reasons for returned MECs.

Unable to Determine:

- 30% - In the remaining eleven cases, BQC was unable to contact either the client or any other knowledgeable person to determine why the MEC was returned. In some of these cases, the address of record didn't exist. In others, the landlord or current tenants were contacted and the client was either unknown to them or had moved up to a year previously.

**PROJECT: RETURNED MAIL PROJECT**

**DESCRIPTION:**

**Purpose:**

This project was designed to verify the correct office address of providers whose mail was being returned to the Department of Public Aid (DPA). These correct addresses would enable DPA to supply the providers with information vital to the implementation of Medicaid policy thereby ensuring improved service to Medicaid recipients. Vouchers were not being returned, but other mail such as provider notices were.

**Design:**

A provider has an "R" designation placed on their file if mail is returned. As of November 17, 1997, there were about 1,800 "R" designations on file out of approximately 48,000 providers. Cases were selected from a report according to geographical location. Even though the provider's office address seemed to be incorrect, we assumed that the payee addresses were correct because payment checks were not returned, nor had the providers notified BMAS of an office address change. This project was conducted in the Downstate counties only. The sample therefore, was not statistically valid.

**Review Protocol:**

BMI field staff attempted a visit to the provider's office to verify the addresses in DPA's records. If the provider was located at the address in DPA's records, the field staff collected the name of a contact person with a phone number (if available). If the provider was not found at that address, BMI utilized various methods to find a current address such as: the phone book, directory assistance, information provided from the contact person, the phone number shown in the provider database, the Automated Wage Verification System (AWVS), the Internet, state income tax information, the Department of Professional Regulation records, the Department of Public Health records, and any other source available. We also contacted recipients in an attempt to locate providers. The Medicaid Management Information System (MMIS) claims history files were also reviewed for providers verified as being out of business or for providers having no address verified. The purpose was to determine if any payments were made to the provider after the date that the provider was no longer eligible to perform a service because they were retired, deceased, or out of business.

**Results:**

Out of 216 cases, we determined the correct office address for 87%:
- 60% of the providers with new addresses,
- 21% of the providers were out of business (retired),
- 6% of the addresses were correct (the U.S. Postal Service could not explain why material was not delivered),

We were unable to determine the correct office address for the remaining 13%:
- 10% of the addresses were not verified,
- 3% of the cases fell into other categories such as provider name changes, test cases, etc.

Claim discrepancies, such as payments after the provider had retired and multiple instances of duplicate billing were discovered on 2 cases.

All cases with new information discovered through our review were returned to BMAS. Recoupment measures were taken by BMI for the two cases with claim discrepancies.

**Follow-Up:**

As of April 2,1998, there were 1644 active providers on the Provider DataBase which have the returned mail indicator.

Two changes were adopted to address the problem. One change was the expansion of the distribution of the Provider Information Sheet to include sending a copy to the provider office address in addition to each payee office. The expanded distribution is intended to improve the provider's notification to the Department of address changes as they occur. The second change implemented on February 20, 1999, effected the following changes:

- The provider's file is changed to non-participating status when the return mail indicator is added to the provider's file.
- A message is added to the Remittance Advice (RA) notifying providers that their claims have been suspended.
- After 30 days have expired and there has been no contact from the provider, their claims are rejected and a different message is placed on the RA.

These changes increase our confidence that we know where the providers are located and that any provider notices or updates are properly distributed.

As of May 10, 2000, there were approximately 413 providers with the "R" indicator on their file - a decrease of 77%.

**PROJECT: POSTMORTEM MEDICAID PAYMENTS**

**DESCRIPTION:**

April 1998-The Office of Inspector General examined if Medicaid payments are made to providers after clients die. The office compared client death records and Medicaid claims.

Go to the OIG webpage at www.state.il.us/agency/oig for the full report and more information. These reports are in Adobe Acrobat format. You may have to download Adobe Acrobat Reader to view reports.

**PROJECT: PAYMENT ACCURACY REVIEW OF THE ILLINOIS MEDICAL ASSISTANCE PROGRAM**

**DESCRIPTION:**

August 1998-The Illinois Department of Public Aid studied payment accuracy in the Medicaid Program, believed to be the first of this type undertaken by a state.

Go to the OIG webpage at www.state.il.us/agency/oig for the full report and more information. These reports are in Adobe Acrobat format. You may have to download Adobe Acrobat Reader to view reports.

**PROJECT: NON-EMERGENCY MEDICAL TRANSPORTATION REVIEWS**

**DESCRIPTION:**

December 1999-High discrepancy rates for medical transportation claims contribute to the growing budget expenditure. The report details the problems and the ways to strengthen monitoring of provider claims.

Go to the OIG webpage at www.state.il.us/agency/oig for the full report and more information. These reports are in Adobe Acrobat format. You may have to download Adobe Acrobat Reader to view reports.

**PROJECT: DEATH NOTIFICATION PROJECT**

**DESCRIPTION:**

February 2000- Poor record keeping and late filing of death notices for former Medicaid residents result in overpayments to nursing homes. The report recommends ways to reduce the overpayments.

Go to the OIG webpage at www.state.il.us/agenc y/oig for the full report and more information. These reports are in Adobe Acrobat format. You may have to download Adobe Acrobat Reader to view reports.

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**INDIANA**

**PROJECT: CHIP ENROLLMENT CENTER MANAGEMENT EVALUATION REVIEW**

**DESCRIPTION:**

Indiana's CHIP Medicaid expansion program is called Hoosier Healthwise for Children. Approximately 500 enrollment centers were established statewide to satisfy federal outstationing requirements that children and pregnant women be given the opportunity to apply for CHIP at locations other than local offices of the Division of Family and Children (DFC).

**Purpose:**

The purpose of the QC pilot was to reduce federal and state misspent dollars by increasing the level of Medicaid case and payment accuracy. By completing a management evaluation review of 73 enrollment centers, QC measured the quality of

outstationing. The reviews consisted of on-site interviews with the enrollment center and corresponding local office staff. Four key elements were evaluated:

- accuracy
- efficiency
- communication
- accessibility

QC staff completed casefile reviews of about 1200 Hoosier Healthwise applications initially processed by enrollment centers to determine the accuracy of enrollment center processing and local office case authorizations. QC also conducted approximately 100 telephone interviews with enrollment center directors who had signed MOAs yet had very low processing activity to determine what, if any, factors may have contributed to their low volume.

**Results:**

The QC Management Evaluation reviews reflected the success of the enrollment center collaboration and community involvement. The general consensus was that enrollment centers are vital to the agency commitment to meet the public's interest in Hoosier Healthwise. They fulfill a valuable community service. Communication between the state agency and enrollment centers was generally very good. However, some enrollment centers requested better agency feedback on case dispositions, and better caseworker responsiveness.

The MEQC case file reviews focused on the major elements of CHIP eligibility, including application date; household composition; enumeration; pregnancy; relationship; citizenship; earned and unearned income; expenses, and health insurance. The hard copy case file was reviewed and compared to the automated case. The average processing time fell within the 45-day federal processing time limits. The elements with the highest deficiency ratings were:

- earned income
- application date
- health insurance
- child support

The MEQC pilot conclusions were incorporated into an Administrative Letter from the Division Director to all local office directors, regional managers, and eligibility staff. The findings afforded local offices an opportunity to discuss needed areas for improvement as they corroborated with the centers regarding MOA extensions. The casefile review findings also provided local offices with valuable information to use in the development of corrective action initiatives.

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**MARYLAND**

## PROJECT: MARYLAND CHILDREN'S HEALTH PROGRAM (MCHP) ELIGIBILITY QUALITY CONTROL (EQC)

The MCHP-EQC Program will be implemented in all Maryland jurisdictions during August 2000. The Program's purpose is to ensure accurate eligibility determinations within the appropriate time limit. The Program's staff (two full time contractual Medical Care Specialist IIs) will review a sample of initial MCHP applications that were deemed eligible by local health department staff.

### Sample Plan:

A monthly sample of 40 active MCHP-only cases will be pulled randomly from coverage groups P02 (Pregnant Women up to 185%), P11 (Pregnant Women 185%-200%), P03 (Newborns), P12 (Newborns of P11 mothers, P06 (Children under one year), P07 (Children between one and six years old), P08 (Children born after 9/30/83, up to 100% FPL, P13 Children born after 9/30/83, up to 185% FPL, and P14 (Title XXI MCHP). An over-sample will be performed to allow for dropped cases; which may include but will not be limited to: those that are listed in error or that are not subjected to review, applicant unwilling to cooperate or provide information, reviewer unable to locate applicant or applicant moved out of state.

In order to maximize the use of staff and other resources, monthly samples will be generated on a regional basis; therefore, one region will be sampled each month. For example, the Central Maryland Region will be sampled and reviewed in January, April, July and October; the Western Region will be sampled and reviewed in February, May, August and November; and the Eastern Region will be sampled and reviewed in March, June, September and December. The State will be divided into three regions; the Central Maryland Region (Carroll, Howard, Anne Arundel, Calvert, St. Mary's Counties and Baltimore City); the Western Region (Garrett, Allegany, Washington, Frederick, Montgomery, Prince George's and Charles Counties); and the Eastern Region (Baltimore, Harford, Cecil, Kent, Queen Anne's, Talbot, Caroline, Dorchester, Wicomico, Somerset, and Worchester Counties). The Bureau of Continuous Improvement utilizes this regional breakdown when reviewing for Comprehensive Program Review System.

### Review Process:

Each case will be monitored via COMAR 10.09.11.4-09 for the following factors:

- -appropriate signatures;
- -application date;
- -decision date and the time between that date and the application date;
- -earned and unearned income;
- -medical verification of pregnancy for all pregnant applicants;
- -social security number;
- -age;

-citizenship;
-residency;
-and any related third-party liability information.

**Corrective Action Planning:**

Data generated from this review process will be utilized in the identification and analysis of error trends; corrective action initiatives will be determined via these data.

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## MINNESOTA

**PROJECT: MINNESOTA FAMILY INVESTMENT PROGRAM LONGITUDINAL STUDY**

**DESCRIPTION:**

The Minnesota Department of Human Services is conducting a five-year longitudinal study of the Minnesota Family Investment Program (MFIP) to examine outcomes related to employment, poverty and welfare dependency. The study is tracking 2,000 participants in: 1) obtaining employment, 2) retaining employment, 3) increasing earnings, 4) reducing poverty, 5) exiting MFIP, and remaining off MFIP. The sample is comprised of Applicants (people new to public assistance when the sample was chosen) and Recipients (people with two or more months of assistance history) of MFIP. Data collection began in May 1998 and is occurring at periodic intervals on the same sample groups throughout the five-year study period. The study also documents the use of income and employment supports such as childcare assistance, housing subsidies, child support and community services. Data will be collected for these participants whether they are on MFIP, exit MFIP, rebound (exit and return to MFIP) or leave the state.

The baseline report, first in a series, was issued in August 1999 (http://www.dhs.state.mn.us/ecs/welfare/LSBAREP.pdf). This report used participant survey and administrative data from May 1998 - October 1998 for those who either converted from AFDC to MFIP or entered the system as new Applicants during that time period. One significant finding from that report was that ten percent of working Applicants and thirteen percent of working Recipients qualified for employer health insurance benefits; however only seven percent of working Applicants and 6% of working Recipients elected to take employer health coverage, usually because the cost of employer coverage was prohibitive.

The second report focused on the Recipient sample and was titled Six Months After Baseline – Recipients http://www.dhs.state.mn.us/ecs/welfare/LS6MREP.pdf . A significant health care finding from that report was that the majority (57%) of exiters had

Medical Assistance (MA) coverage for themselves and/or family members during the sixth month after baseline. The entire Baseline and Six-Month Recipient reports can be found online at the websites listed.

The next report, Six Months After Baseline - Applicants, focuses on the Applicant sample and is scheduled for release in July 2000 and will also be available on the Minnesota Department of Human Services website http://www.dhs.state.mn.us/infocenter after the July release date. Other reports in the next year are scheduled for release in October 2000, January 2001, and June 2001. The January 2001 report will focus heavily on data currently being collected on exiters and rebounders; health care options available to this population, participants awareness of medical programs at time of exit, reasons for not applying for any of the available medical programs, types of medical services used, and health care coverage for rebounders for the time they were off MFIP. Health care coverage is an important component to participants sustaining self-sufficiency and this study provides healthcare and cash program management with important information on health care coverage as it relates to the success or failure of the MFIP participants to exit and remain off welfare.

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## NEW MEXICO

New Mexico continues to review the Aged & Disabled recipients and the review of resources either unreported or transferred for eligibility purposes. The target areas in the Medicaid categories for children are the potential for insurance for children either from Absent Parents or from the parent(s) with insurance options that are included in their employment. MQC is reviewing the Medical Assistance categories for children for accuracy and to ensure all children are covered either by NM Medicaid or other insurance when available.

For all of these reviews the MQC reviewer conducts a full review of elements per MAQC procedures to continue review of accuracy of benefits issued. The findings so far have been all of the Aged/Disabled reviews have been accurate. In the Medicaid categories for the children, the trend has been many parent(s) that are employed either have the insurance option but cannot afford it or the employment status does not meet the insurance criteria. The other trend is that the employer does not offer insurance to their employees.

Overall, the reviews for accuracy for these categories have been excellent.

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## NEW YORK

## PROJECT: RECOVERING INCOME AND RESOURCES FROM INSTITUTIONALIZED MEDICAID RECIPIENTS' SPOUSES LIVING AT HOME

**DESCRIPTION:**

New York State has a State supervised, county administered program. Therefore, we targeted our MEQC waiver projects to review each sampled county's processes for recovering income or resources from spouses living in the community to assist in covering the cost of care for their institutionalized spouses.

### Putnam County

**Purpose:**

To obtain information on Putnam's processing of Medicaid cases involving the Community Spouse of recipients of Long Term Care. All cases reviewed involved Community Spouses that had refused to make excess income and resources available to meet the Institutionalized Spouse's cost of Long Term Care.

**Design:**

State audit staff investigated all phases of the eligibility determination process applied in Putnam County for this category of clients. Following the opening of Long Term Care, auditors mapped out the district's efforts to secure the cooperation of the Community Spouse and the recovery of resources and the application of income.

**Results:**

It was found that Putnam County had independently developed an efficient tracking system to recover resources from the estate of a non-cooperative community spouse. We also determined that many of the difficulties the district had with recoveries from spouses involved the court system. Various courts had interpreted Medicaid regulations differently. Therefore, the district modified its operations so that support petitions were filed on a timely basis in a court of appropriate jurisdiction.
The State Department of Health concluded that Putnam County had developed and was operating an efficient process for the investigation and recovery of income and resources.

### Suffolk County

**Purpose:**

To identify and assess district procedures and performance in recovering excess income and resources from the non-cooperative community spouse of an Institutionalized Spouse in Long Term Care.

**Design:**

For the last 7 years Suffolk had been using a recovery process that they had developed independently of the State Department of Health. This process concentrated on income and involved the training of both social services staff and county attorneys who are responsible for petitioning the courts for recoveries. The district's strategy involved a willingness to negotiate settlements with the community spouse and their legal representatives that would ensure some recoveries while permitting the community spouse to maintain sufficient funds to meet his/her needs. The review looked at the County's recovery process, and reviewed a sample of 101 cases to verify that County strategies were successful in recovering funds.

**Results:**

At the beginning of our audit the district did not have written procedures in place detailing the recovery process. We also found that cases were prioritized for recovery based on a favorable response by the community spouse to a demand letter for cooperation in the application of excess income and resources to the institutionalized spouse's cost of care. This district did not pursue recoveries where only excess income or only excess resources existed and did not consistently pursue community spouses that refused to respond to the initial demand letter. About the time this audit concluded, the district had begun to file court petitions for support when no responses had been received following a second notice to the community spouse. In addition, they had begun detailing the recovery process in writing, as well as centralizing responsibility for all referrals for support.

**Oneida County**

**Purpose:**

A review was conducted in this district to determine the extent of community spouse's (CS) refusal to contribute excess income and resources for the cost of the institutionalized spouse's (IS) cost of care. The second purpose was to examine the referral and recovery process used by Oneida County.

**Design:**

We reviewed 229 active December 1998 cases, and 62 cases that were opened during the period January through June 1999. All these cases had spouses who lived in the community.

**Results:**

Of 229 cases active in December 1998 with an institutionalized individual with a spouse in the community, seven cases were found where the CS refused to contribute either excess income or resources. In all seven of these cases the community spouse did not

attempt to conceal information on income or resources. Only five of these 7 cases had excess resources amounting to $527,834. Of the 62 additional cases that were opened between January and June 1999, we found only one case in which the CS had refused to contribute to the IS's cost of care. However, this single case had excess resources of $577,914

The review of the resource recovery process revealed that the district had taken no action to recover resources that exceeded the community spouse resource limit. However the district planned to initiate recovery actions on 5 of 6 cases.

The review of the application approval process indicated that district staff was not consistent in their knowledge and application of spousal refusal policy. However, staff were correct in their application of the policy that CS's were not permitted to retain excess resources to generate income to bring him/her up to the Minimum Monthly Needs Allowance unless by court order or fair hearing. The eligibility examiners were also accurately calculating and applying the transfer penalty period for resource transfers prior to application. And, staff were correctly budgeting the income of the institutional spouse to bring the community spouse up to the minimum monthly income allowance.

**NYC 1998**

**Purpose:**

To identify and assess district procedures and performance in recovering excess income and resources from the non-cooperative community spouse of an Institutionalized Spouse in Long Term Care. Our review also investigated the recovery process in place in the Office of Revenue Investigation (ORI).

**Design:**

From January through May 1998, the Nursing Home Eligibility Division of NYC approved 443 applications for nursing home coverage for individuals with spouses in the community. A total of 221 of these cases were reviewed, 179 of which the CS had refused to make income and or resources available for the cost of the institutionalized spouse’s nursing home care. The audit also reviewed ORI action on the referred cases.

**Results:**

No attempts were made by the clients to conceal their excess resources. All the information necessary for the district to evaluate these resources was provided with the application. In 75% of the refusal cases the clients had obtained the services of either an attorney, nursing home staff or elder care consultants. And, there was no indication that clients were using trusts or transfers of assets to avoid their responsibility of supporting the institutionalized spouse.

Recovery actions were not taken on 69% of the cases referred for recovery to the Office of Resource Investigation. There were insufficient records maintained in ORI to determine their policy for pursuing a recovery or dropping a case.

**PROJECT: REVIEW OF ELIGIBILITY DETERMINATIONS**

**DESCRIPTION:**

New York State has a State supervised, county administered program. In 1999, a major part of our waiver project efforts were assigned to reviewing NYC's (the largest social service district in the State) recertification determinations for recipients living in the community.

**Purpose:**

Quality Control eligibility reviews were conducted to obtain information on eligibility determinations made by New York City Medicaid staff (known as Medical Assistance Program, or MAP, in NYC). Monthly samples were drawn from the active case population of Medicaid only community cases that consisted of the following categories: Low Income Families, Medically Needy - ADC Related, Pregnant Women and children determined eligible under the Federal Poverty Level, and Single Adults and Childless Couples. MAP and the State Dept. of Health analyzed data for corrective action purposes.

**Design:**

Auditors determined case eligibility and correct category of assistance for sampled individuals by reviewing agency files and other government records, making collateral contacts with third parties such as employers and landlords, and interviewing recipients.

To the extent possible auditors based their determinations on information that was available to the MAP caseworkers. However, due to problems with case record retrievals, we were often unable to determine the source of the error and accurately assign cause to either the client or agency. Therefore in many error determinations the cause appears to be shared by the client and agency.

Three hundred and ninety-six eligibility reviews were selected for review. Fifty cases were dropped from review, 46 of which were due to the client's refusal to cooperate or A&QC's inability to locate the clients. MAP is in process of expediting recertifications in order to secure cooperation.

**Results:**

The project found that 91 of 280 completed reviews had variances in earned income. The variances in thirty-seven of the 91 cases resulted in countable QC findings. MAP failed to budget any earned income in 10 of the 54 cases in which income variances did not affect

MA eligibility. In the remaining 44 cases the agency budgeted incorrect earned income. We could not determine fault for these variances.

Twenty-two cases were found to have variances in household composition.

Five of 9 cases had findings involving Social Security income that resulted in an ineligible case member or an understated liability.

The final report will be issued for comments during early September 2000.

**NYC 2000**

Like our 1999 project, the 2000 project also looked at eligibility determinations of Community MA-Only cases in New York City.

In order to overcome the problems with case record retrieval, our sample was randomly selected from the physical case records of recently completed recertifications. Cases selected for review consisted of the following types:

- Low Income Families (LIF)
- Medically Needy AFDC Related
- Pregnant women and children determined eligible under the Federal Poverty Level
- Single Adults and Childless Couples

At this time an interim report on the results of the first two months is nearly completed. A draft report has been shared with MAP and DOH. Our preliminary findings indicate that eligibility errors are concentrated in the area of earned income. The great majority of these errors occurred due to misapplication of earned income information provided by the client at recertification.

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## OHIO

**PROJECT: REVIEW OF DENIAL/TERMINATION ACTIONS OF HEALTHY START AND TRANSITIONAL CASES (W, C, R-5/30/00, ER)**

**October 1998-September 1999**

The review was divided into two six-month periods. Fourteen counties were reviewed during the first period (October through March) and sixteen counties were reviewed during the second period (April through September). Approximately 20-25 Healthy Start and Transitional termination/denial actions were selected per county per month, and reviewed for compliance with policy. This process included a review of online CRIS-E case information and hard copy case files. Interviews were attempted with each client

subject to the termination/denial action. A total of 3025 negative action reviews were completed.

The results indicate that, for these thirty counties as a group, 22.94% of all Healthy Start and transitional Medicaid denials and terminations were done incorrectly. The county's rates of inappropriate denials ranged from 7.21% to 39.13%.

The primary reasons for inappropriate denials or terminations included: terminating Medicaid when the assistance group failed to complete a face-to-face food stamp certification interview, requesting income verifications for newborns, pregnant women, and step parents then subsequently terminating/denying coverage when verifications are not provided, terminating/denying coverage without sending appropriate notices, and terminating/denying Medicaid due to incorrectly determining earned income.

**October 1999-September 2000**

Ohio has continued to review denial/termination actions. For FFY 2000, thirteen counties are receiving a comprehensive review consisting of 50 active, 15 negative reviews, and surveys/interview observations of clients, and county department of human services supervisors, eligibility workers, and screeners.

Ohio is also conducting a follow-up review of 28 counties who participated in the FFY99 review process. These 28 counties inappropriately denied or terminated 10% or more of the cases selected for review during the FFY 99 project.

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## OREGON

**PROJECT: OREGON HEALTH PLAN**

**Background:**

The State is currently operating the MQC pilot program under an 1115 waiver. The program (Oregon Health Plan - OHP) certified eligible persons for six months and delivered Medicaid benefits through managed care based on a prioritized list of medical conditions and treatments.

**Description:**

Several projects are ongoing in OHP to strengthen program integrity and continue to enhance customer service. These projects include:

- **The Pregnancy/Unborn Project -** Applications are screened at the OHP Processing

Center to identify households containing pregnant women. Applications for this project are processed within 24 hours. In addition, an evaluation is completed on those pregnant teens 16 years or younger. For those determined to be high risk, a referral for case management is made to the local branch office.

- **The Enhanced Verification Project -** This project was approved by the Oregon Legislature in July 1999 and is ongoing. The focus is on a more in-depth review of applications utilizing wage history, unemployment compensation history and child support. These potential income sources are checked against all adult applicants as part of the continuing commitment to program integrity. The project began with re-applications only but has expanded to the entire application process.

- **High Risk Profile Project -** This project focuses on those applications with information that contradicts with information found on the various state wage match, child support or BENDEX records. Specialized workers provide further review of these applications to ensure that all questions are resolved prior to completion of the eligibility decision.

- **Medical Program Out-stationed Eligibility Specialists** - Experienced eligibility workers have been out-stationed in various field offices to provide medical support and expertise on medical eligibility. These workers maintain a strong connection to the OHP Central Processing Center, which keeps them up to date on medical program changes. In addition, they have increased the focus on identifying third party medical resources that can provide long term support for families.

- **Medical Program Training -** OHP Central Processing Center has created a comprehensive training course for eligibility staff. Initially, new OHP staff receives 240 hours of on-the-job training in a classroom setting. On-going, incumbent staff receive periodic refresher training. This comprehensive training course provides an excellent environment for learning OHP eligibility and processing client applications. This process includes a full time instructor and peer reviews for accuracy.

- **Internal Review Process** - This process has provided a responsive method for pin-pointing training issues. Eligibility staff who complete the formal training program return to the OHP Central Processing Center for an on-the-job training period that includes reviews of the applications they process. As eligibility staff improve their individual knowledge and accuracy, the lead workers review fewer cases.

- **Bar Code Tracking** - In the last year, bar coding has been added to most OHP applications. This allows the application to be tracked from the time it enters the Processing Center until the eligibility decision is made. Clients are able to learn the status of an application and the program can identify the worker handling the case.

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## PENNSYLVANIA

### PROJECT: MANAGED CARE CASE REVIEW

**Goal:**

The purpose and focus of this project is to review eligibility of managed care cases. Project was implemented 10/97 and has been approved through 9/00.

**Sample:**

1,112 cases reviewed 10/97-9/98.

**Findings:**

For the period of 10/97-9/98, 1,112 managed care cases were reviewed with 52 cases found in error for a case error rate of 4.7%. Out of a total sample case benefit amount of $362,129, QC cited $12,011 in error, which was a payment error rate of 3.32%.

### PROJECT: NEGATIVE CASE REVIEW

**Goal:**

The purpose and focus of this project is to ensure that medical assistance is continued for each eligible person when TANF benefits are terminated. The project was implemented 10/99 and has been approved through 9/00.

**Sample:**

Approximately 2400 case reviews

**Findings:** Pending

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## TEXAS

**DESCRIPTION:**

In FFY 2000 Texas continues to review QMB, SLMB, and QI 1 cases to measure the impact of changes made in the client declaration certification process. Based on the results of the 1999 pilot activity, in September 1999 Long Term Care program staff implemented changes such as modification to the streamlined application form for these programs. Further comparisons of the two years' pilot results will be used to evaluate the accuracy, feasibility, and cost-effectiveness of continuing the modified QMB/SLMB/QI1

application process. Texas QC continues to review for all elements of eligibility and identify ineligible cases as well as provide information related to unreported or under reported income and resources.

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## UTAH

**PROJECT: FOCUSED REVIEW OF FAMILY RELATED MEDICAID CASES, AGED, AND DISABLED CASES. JULY, 1999 TO SEPTEMBER, 2000**

**Purpose:**

To determine if Medicaid clients are being well served by two different departments determining eligibility throughout the state.

**Design:**

Targeted program types are AM, DM and also Family category cases such as CM, FM, FM-TP FM-12, NB, NB+, PN and PN+. The Department of Health has approximately 48% of the cases pulled. The Department of Workforce Services has approximately 52% of the cases pulled for review. Both active and negative cases are being pulled. A client survey is also being completed for feedback on service.

Errors are cited on cases that result in a wrong spenddown amount and/or cases that were not opened under the most beneficial program. Also assets and income are reviewed to determine if cases are opened or closed correctly

**Results:**

Still ongoing. All findings on cases are sent to the workers for feedback and corrective action if needed.

**PROJECT: HMO COORDINATION OF BENEFITS, APRIL 2000**

**Purpose:** To determine if HMOs are utilizing the full potential of TPL.
**Design:** Currently in progress.
**Results:** Just starting project.

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## VIRGINIA

**DESCRIPTION: TWO-PHASE TARGETED REVIEWS**

**Phase I - Conduct Evaluations of Local Agencies that contributed at least 3% to Case Eligibility Error Rate.**

The Departments of Social Services and Medical Assistance agreed to target local agencies with the highest percentage contribution to the state Medicaid case eligibility rate. We selected 7 local agencies, all with case error rates 3% or greater. The database for local agency selection included completed QC reviews for the periods October 95 - September 97 and October 96 - September 98. The universe included both ABD and Family and Children cases. This pilot is effective for the April 99 - March 00 sample periods.

**Phase II - Evaluate Actions on Long Term Care Cases.**

In this phase, only long-term care reviews would be included. All local agencies in the state would participate. The sample would include Community Based care recipients and recipients receiving care in a medical institution (such as nursing home, or Mental Health and Mental Retardation facility) but excludes SSI cases and Adult Care Residences. This pilot is effective for the April 00 - March 01 sample periods.

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## WASHINGTON

**PROJECT: PHARMACY SURVEY**

**Goals:**

Determine whether clients received correct prescriptions from designated pharmacies; whether pharmacies followed correct procedures; level of client satisfaction with services received from those pharmacies.

**Sample:**

Random statewide sample of 116 clients who had 129 claims to a pharmacy between January and April 1999. Pharmacy A, the first pharmacy selected, was a large chain with 150 stores in Washington State, selected because of complaints about poor quality of care reported to the Pharmacy Board. Conducted face-to-face interviews with sampled clients.

**Findings:**

No discrepancies between medication prescribed and issued. Majority of clients were generally satisfied with the service they got from their store. Recommended conducting a second survey with another pharmacy to compare survey results. Report completed.

**PROJECT: TERMINATED KIDS**

**Goals**:

Determine whether children terminated from the Children's Medical Program (H) continue to get medical coverage.

**Sample**:

Random statewide sample of children terminated from H. Conducted review of case through ACES (Washington's computerized eligibility system), some phone interviews with parents.

**Findings**:

The majority of children terminated from the Children's Medical Program are re-opened on Medicaid under another program, payee or assistance unit. Survey completed, report in progress.

**PROJECT: WHEELCHAIRS**

**Goals**:

Determine whether clients receive wheelchairs/accessories authorized by the Medical Assistance Administration (MAA) for them; level of client satisfaction with wheelchair supplier and wheelchair; whether wheelchair meets clients needs.

**Sample**:

Random statewide sample of aged and disabled clients authorized wheelchairs/accessories by MAA. Sample included clients in their own homes and clients in Nursing Facilities (NFs). Conducted face-to-face interviews with clients, parents, caretakers and NF staff.

**Findings**:

The majority of clients had received the wheelchairs/accessories MAA authorized and were very satisfied with their supplier and the wheelchair. Survey completed, analysis in progress.

**PROJECT: TANF TERMINATION/MEDICAL REDETERMINATIONS**

**Goals**:

Determine whether staff are redetermining medical eligibility for clients terminated from TANF cash assistance.

**Sample**:

Initial: Random statewide sample of clients terminated from TANF in August, September, and October 1999. Secondary: Random statewide sample of clients terminated from TANF in May 2000. Conducted review of case actions through ACES.

**Findings**:

Initial findings of incomplete redeterminations resulted in changes to ACES and statewide training. Secondary sample selected to determine the results of these changes. Survey complete, data input in progress.

**PROJECT: WHY HEALTHY OPTIONS (HO) CLIENTS CHANGE PLANS 1999**

**Goals:**

Determine why HO (Washington's Medicaid managed care) clients changed plans in 1999; identify enrollment/disenrollment problems; identify program/process improvements to decrease the number of clients changing plans; compare survey results to results of similar project conducted in 1998.

**Sample**:

Random statewide sample of clients who changed plans in 12/99.

**Findings**:

As in previous project, majority of clients changed plans to follow their provider (PCP, specialist or clinic). Few changed because of coverage or quality issues. 1998 project identified several process/program problems which have been largely resolved. Report completed.

**PROJECT: INCONTINENT SUPPLIES**

**Goal:**

Determine whether clients receive the incontinent supplies authorized by MAA for them; level of client satisfaction with supplier and supplies; whether supplies meet clients needs.

**Sample:**

Random statewide sample of clients authorized incontinent supplies in December, 1999 and February 2000. Conducted face-to-face interviews with clients, parents, and caretakers.

**Findings:**

Survey complete, analysis in progress.

**PROJECT: DACs (Disabled Adult Children)**

**Goal:**

Determine whether Community Service Office (CSO) staff reviewed lists of clients identified as DACs in ACES, sent to them in August 1999. CSOs were to review each name and determine whether client was a DAC or not, and correct coding as necessary.

**Sample:**

All names on DAC lists sent to CSOs in 8/99. Conducted review of cases through ACES.

**Findings:**

Survey complete, data input in progress.

**PROJECT: NURSING FACILITY TRUST ACCOUNTS**

**Goal:**

Determine whether clients in NFs have a trust account; review deposits and expenditures to determine whether income has been reported and expenditures are appropriate; determine whether trust account information has been correctly reported and entered in ACES; determine whether clients were resource eligible.

**Sample:**

Random statewide sample of NF clients. Reviewing for the months of May through July 2000. Conducting review of cases through ACES and in-person visit to NFs.

**Findings**:

In progress.

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## WEST VIRGINIA

**PROJECTS:**

Fiscal Year 1999: Focus on Recipient Eligibility.

**Long Term Care cases:**

Targeted reviews of Nursing Home cases focusing on error prone elements, income and assets.

Non-emergency medical transportation payments. A review of eligibility for payments.

Fiscal Year 2000: Focus on Nursing Home and Pharmacy billing

**Long Term Care cases:**

Review of assets of Nursing Home patients by checking courthouse records for assets or asset transfers.

**Pharmacy Billing:**

Review of billing by pharmacies for prescriptions that require prior approval.

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