REPORT TO THE
COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

Functioning Of The Florida System For Reviewing The Use Of Medical Services Financed Under Medicaid

B-164031(3)

Social and Rehabilitation Service
Department of Health, Education, and Welfare

BY THE COMPTROLLER GENERAL
OF THE UNITED STATES

JUNE 9, 1972

COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

B-164031(3)

Dear Mr. Chairman:

This is the second of four reports on our reviews of the functioning of State systems for reviewing the use of medical services financed under Medicaid, a grant-in-aid program administered by the Social and Rehabilitation Service of the Department of Health, Education, and Welfare. Our reviews, which were made pursuant to your request of July 2, 1971, were made in Florida, Maryland, Massachusetts, and Missouri. This report describes the utilization review system in Florida.

As agreed by the Committee Staff, copies of this report are being made available to the Secretary of Health, Education, and Welfare. We believe that the contents of this report would be of interest to committees and other members of Congress. Release of the report, however, will be made only upon your agreement or upon public announcement by you concerning its contents.

Sincerely yours,

Comptroller General
of the United States

The Honorable Wilbur D. Mills
Chairman, Committee on Ways and Means
House of Representatives

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ABBREVIATIONS

GAO	General Accounting Office
HEW	Department of Health, Education, and Welfare

COMPTROLLER GENERAL'S REPORT
TO THE COMMITTEE ON
WAYS AND MEANS
HOUSE OF REPRESENTATIVES

FUNCTIONING OF THE FLORIDA SYSTEM FOR REVIEWING THE USE OF MEDICAL SERVICES FINANCED UNDER MEDICAID
Social and Rehabilitation Service
Department of Health, Education, and Welfare B-164031(3)

D I G E S T

WHY THE REVIEW WAS MADE

This is the second of four reports by the General Accounting Office (GAO) on methods followed by States in reviewing the use of medical services financed under the Medicaid program. The reports were requested by the Chairman, House Committee on Ways and Means.

The Chairman suggested that GAO inquire into such matters as the

--identification and correction of excessive use of medical services,

--results achieved under systems established by States to review uses of Medicaid,

--adequacy of State resources providing for the review systems, and

--extent of assistance given by the Department of Health, Education, and Welfare (HEW) to States in developing these systems.

Background

State reviews of medical services under Medicaid are conducted to safeguard against unnecessary medical care and services and to determine that payments financed by Medicaid are reasonable and are consistent with efficiency, economy, and quality care.

State reviews of the use of medical services under Medicaid are referred to in this report by the technical term "utilization review systems" but in this digest are referred to simply as review systems.

This report covers the review system followed in Florida. GAO's report on the review system followed in Missouri was issued March 27, 1972. Other reports will cover the systems followed in Maryland and Massachusetts.

Medicaid is a grant-in-aid program administered by HEW. The Federal Government shares with States the cost of providing medical care to persons unable to pay for such care. The Federal share in each State depends upon the per capita income of the State. In Florida the Federal share of Medicaid in fiscal year 1971 was just over 64 percent.

In fiscal year 1965, prior to Medicaid, total Federal-State medical assistance expenditures amounted to $1.3 billion. Under Medicaid such expenditures increased rapidly and amounted to about $3.5 billion in fiscal year 1968.

Congressional concern over Medicaid costs led to amendments to the Social Security Act requiring that each State include a system to review the uses of Medicaid.

Therefore, in this series of reports, GAO is evaluating:

1. General review controls applicable to all medical services.

2. Specific controls applicable to institutional medical services.

3. Specific controls applicable to noninstitutional medical services.

HEW and Florida officials have not examined and commented on this report formally; however, matters in the report have been discussed with them.

FINDINGS AND CONCLUSIONS

During fiscal year 1971 Florida paid about $81 million for medical benefits furnished to about 245,000 welfare recipients. Of the $81 million, about $77 million was paid to 6,087 providers of medical services and about $4 million was paid to the Social Security Administration for Medicare insurance premiums. The Federal share was about $52 million.

Florida has developed a review system which includes manual and computer controls. These controls are

designed to assist in identifying and evaluating services that exceed established standards and in correcting uses of Medicaid that are determined to be improper.

Florida's review system is conducted by its Bureau of Medical Services. The bureau's review committee includes a physician, a pharmacist, a medical social worker, representatives from units that process claims, and a representative from the data processing center. (See p. 13.)

Florida's review system does not provide for accumulation of data showing (1) the reductions in Medicaid costs or other benefits resulting from reviews or (2) a comparison of review costs with the benefits provided.

Florida's system, however, is producing positive results. Use of claims-processing procedures resulted in reducing claims for payment by hospitals by about $268,000 over a 4-month period. Claims for payment for skilled nursing-home care were reduced by about $222,000 during an 11-month period. Additional reductions of about $86,000 in claims for payment, primarily by physicians, resulted from actions taken by the review committee on cases referred for resolution. (See p. 18.)

Controls applicable to all Medicaid services

Florida has established procedures to determine that claims paid are

- --for services rendered by eligible providers to eligible recipients,
- --for services of the kind and to the extent authorized under the program, and
- --limited to reasonable charges. (See p. 19.)

Controls applicable to Medicaid institutional services

Florida's preauthorization of services (advance approval to provide services) and its system for processing claims for payment provide many effective controls applicable to Medicaid institutional services. No utilization review program was established, however, for patient care in tuberculosis and mental hospitals.

Of the $81 million paid by Florida for Medicaid services in fiscal year 1971, about $58 million, or 72 percent, was for institutional services, principally in nursing homes and hospitals. (See pp. 21 and 26.)

Medical reviews of nursing-home care have been effective in identifying patients placed inappropriately for the levels of care they required. Reviews of the care of 5,765 patients during a 9-month period showed that 1,044 patients had been placed inappropriately. GAO estimated that additional program costs of $82,000 resulted from these inappropriate patient placements. (See p. 22.)

Results of these medical reviews and of corrective actions taken, however, have not been made available to the State's review committee to enable it to identify nursing homes and physicians that overused nursing-home care or to evaluate the adequacy of corrective actions taken. The review committee does not evaluate nursing-home care. (See p. 23.)

Florida has not fully implemented provisions of its review plan for hospital services which require that

- --hospitals submit review plans and reports involving Medicaid patients and
- --review activities carried out by hospitals be monitored by Florida's Department of Health. (See p. 24.)

Florida's review plan requires authorization for hospital stays exceeding 15 days. Selection of cases for evaluating the need for continued care was made from cases in which the stays exceeded 15 days, without regard to patient diagnoses and other pertinent information. Selection of cases for evaluating the need for continued care should be made in relation to the patients' medical diagnoses and lengths of stays compared with the average length of stay for all patients having the same diagnosis. (See p. 25.)

Controls applicable to Medicaid noninstitutional services

Florida has an effective review system for physician services and prescribed drugs. (See p. 32.)

Payments for physician services and prescribed drugs, the principal noninstitutional services, amounted to

about $18.5 million, or 23 percent of Florida's Medicaid expenditures.

Because physician services are basic to all other medical services, most review work has been devoted to this area. The State has established a number of specific controls aimed at controlling the use of physician services. (See p. 28.)

The State relies almost exclusively on its preauthorization and computer systems to control the prescribed-drug program. (See p. 29.)

The review of physician services and prescribed drugs can be improved by

- --developing histories of the use of the program by providers and recipients to assist in identifying the underlying causes of improper uses,
- --using statistical-sampling techniques in selecting cases for review, and
- --keeping records on the results obtained by the different levels of review. (See p. 32.)

Adequacy of State resources for utilization review

Florida's review system is operated by 63 employees. Review provisions of Florida's Medicaid plan have not been implemented fully. State officials expressed the view, and GAO concurred, that this was due, in part, to the lack of staff for review activities.

In its budget request for fiscal year 1973, Florida's Bureau of Medical Services provided for 37 additional positions to be used for surveillance and review activities. Considerable improvement in review activities could be achieved if the funds were obtained and used properly. (See pp. 33 and 34.)

Extent of assistance by HEW

The Florida Medicaid program began in January 1970. The development of its review system appears to be primarily a result of the State's initiative, rather than a result of specific assistance by HEW.

In October 1971 HEW provided Florida with a model management information system having a broad framework

within which the State could develop detailed system specifications to meet requirements particular to its own system. At the conclusion of GAO's fieldwork in December 1971, State officials had not reviewed and evaluated HEW's model system. GAO was informed that those parts of the HEW system that could be adopted easily would be used. (See p. 36.)

RECOMMENDATIONS OR SUGGESTIONS

HEW should assist the State and should monitor the State in its actions to

--provide for the systematic accumulation of data enabling a comparison of the costs of utilization review with the benefits it provides and

--study the HEW model system for the purpose of adopting design features offering opportunity for improvement. (See p. 38.)

CHAPTER 1

INTRODUCTION

In response to a request dated July 2, 1971 (see app. I), from the Chairman, House Committee on Ways and Means, we reviewed the functioning of the Florida Medicaid utilization review system. We made our review at State and Federal offices having responsibilities relating to utilization review activities under the Medicaid program.

As requested by the Committee, we inquired into the

--identification and correction of excessive use of medical services,

--results achieved under the utilization review system,

--adequacy of State resources providing for utilization review, and

--extent of assistance given by the Department of Health, Education, and Welfare to the State in developing the system.

To obtain information on the first two of these matters, we evaluated the State's (1) general utilization review controls, (2) specific controls applicable to institutional medical services, and (3) specific controls applicable to noninstitutional medical services.

HEW and Florida officials have not examined and commented formally on this report; however, the matters discussed in the report have been discussed with them.

This is the second of four GAO reports on methods followed by States in reviewing the use of medical services financed under Medicaid. Our first report on the utilization review system followed in Missouri was issued on March 27, 1972.[1] Other reports will cover the systems followed in Maryland and Massachusetts.

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[1]Report to the Committee on Ways and Means, House of Representatives (B-164031(3)), on Functioning of the Missouri System for Reviewing the Use of Medical Services Financed Under Medicaid.

DESCRIPTION OF MEDICAID PROGRAM

The Medicaid program, authorized in July 1965 as title XIX of the Social Security Act, as amended (42 U.S.C. 1396), is a grant-in-aid program under which the Federal Government shares with States the costs of providing medical care to needy persons. The Federal share ranges from 50 to 83 percent, depending on the per capita income in the States. The Federal share of Florida's Medicaid costs in fiscal year 1971 was 64.10 percent.

Medicaid, like other public assistance programs, is a Federal-State program operated under State direction within Federal guidelines. Within such guidelines each State sets the eligibility factors governing who will be included in the program and what services they will be entitled to receive and establishes procedures for the administration of the program.

Services provided to Medicaid recipients vary from State to State. All States must provide certain basic medical services required by law; that is, inpatient and outpatient hospital care, laboratory and X-ray services, skilled nursing care for persons 21 years of age or older, home health services for persons entitled to skilled nursing care, screening and treatment for persons under 21 years of age, and physicians' services. Transportation is required by HEW regulation. Additional services--such as dental care, prescribed drugs, eyeglasses, and care for patients 65 years of age or older in institutions for mental diseases and/or for tuberculosis--may be included if a State so chooses.

As of March 1972, 48 States, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands had Medicaid programs. During fiscal year 1971 States and jurisdictions having Medicaid programs spent about $5.9 billion, of which about $3.2 billion represented the Federal share.

ADMINISTRATION OF MEDICAID PROGRAM

Medicaid is administered at the Federal level by the Social and Rehabilitation Service, HEW. Under the act States have the primary responsibility to initiate and administer their Medicaid programs. State plans--which provide the bases for Federal grants to States for their Medicaid programs--are approved by the 10 Regional Commissioners of the Service.

The HEW Regional Commissioners determine whether State programs adhere to the provisions of approved State plans and to Federal policies, requirements, and instructions

contained in HEW's Handbook of Public Assistance Administration and in program regulations. The Regional Commissioner in the Service's regional office in Atlanta, Georgia, provided general administrative direction for the Medicaid program in Florida.

The HEW Audit Agency is responsible for auditing the manner in which Federal and State responsibilities for the Medicaid programs are being discharged. The HEW Audit Agency has made--and is currently making--a number of reviews of State Medicaid programs. In reports released in October 1971 and January 1972 on Florida's Medicaid program, the HEW Audit Agency called attention to limited utilization review efforts and to the need for Florida to improve its policies and procedures to ensure an effective utilization review program.

PERSONS ELIGIBLE FOR MEDICAID

Persons receiving public assistance payments under other titles[1] of the Social Security Act are entitled to Medicaid. Almost all other persons covered by Medicaid are persons whose incomes or other financial resources exceed standards set by States to qualify for public assistance payments but whose resources are not adequate to pay the costs of their medical care. Coverage of this latter group is at the option of States. Persons receiving public assistance payments generally are referred to as categorically needy persons, whereas other eligible persons generally are referred to as medically needy persons.

As of January 1972, 27 States or jurisdictions had Medicaid programs covering both the categorically needy and the medically needy and 25 States or jurisdictions, including Florida, had programs covering only the categorically needy.

REQUIREMENTS FOR UTILIZATION REVIEW

In fiscal year 1965, prior to Medicaid, total Federal-State medical assistance expenditures amounted to $1.3 billion. Under Medicaid such expenditures increased rapidly and amounted to about $3.5 billion in fiscal year 1968.

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[1]Title I, old-age assistance; title IV, aid to families with dependent children; title X, aid to the blind; title XIV, aid to the permanently and totally disabled; and title XVI, optional combined plan for titles I, X, and XIV.

Congressional concern over rapidly rising Medicaid costs led to legislative action in 1967. As a result, an amendment to the Social Security Act required that each State Medicaid plan provide methods and procedures (utilization review systems) to safeguard against unnecessary utilization of medical care and services and to ensure that payments are not in excess of reasonable charges consistent with efficiency, economy, and quality care.

HEW implementation

To implement this legislative requirement, the Social and Rehabilitation Service issued an interim regulation on July 17, 1968, which, after minor modification, was issued as a program regulation on March 4, 1969. The regulation specifies that each State plan provide for a utilization review for each type of service rendered under the State's Medicaid program.

The regulation also requires that the responsibility for making utilization reviews be placed in the medical assistance unit of the State agency responsible for administering the program. The regulation permits delegation of responsibility for utilization review activities for Medicaid inpatient hospital and nursing-home services to the agency monitoring such activities under title XVIII of the act (Medicare).

Because there are 52 widely differing medical assistance programs under Medicaid, the language of the regulation is quite broad and permits States considerable latitude in their approaches to utilization reviews.

The regulation does not specify the manner in which utilization reviews are to be made or establish minimum requirements for utilization review plans.

In April 1969 the Service sent draft guidelines for utilization reviews to its regions for comment. The guidelines stated that (1) institutional services should be reviewed for necessity of admission and duration of stay and (2) noninstitutional services should be subject to surveillance to ensure that services rendered were based on actual need and that frequency of care and service was appropriate to needs.

The draft guidelines stated also that utilization reviews should include (1) methods to review needs for medical services before services were provided and (2) reviews to determine the propriety of individual claims and to

accumulate, analyze, and evaluate claims data to identify patterns and trends of normal and abnormal use of services.

On December 21, 1971, the Service issued its first guidelines for implementing the March 1969 utilization review program regulation. These guidelines contain information regarding State responsibility and administrative criteria for preauthorization of selected types of medical care and services.

FLORIDA'S MEDICAID PROGRAM

Florida started its Medicaid program on January 1, 1970. The program is limited to persons receiving public assistance payments--the categorically needy--or to persons who could receive public assistance if they were not in medical institutions.

In addition to providing the basic Medicaid services described on page 8, Florida pays for (1) prescribed drugs, (2) care for persons 65 years of age and over in tuberculosis and mental hospitals, and (3) Medicare insurance premiums for Medicaid recipients aged 65 or over. During fiscal year 1971 Florida provided Medicaid services to about 245,000 persons.

The following table shows, by category of medical service, the number of eligible and participating providers of medical services, number of recipients, and program expenditures for fiscal year 1971.

Medicaid services	Fiscal year 1971			
	Providers of medical services			
	Eligible	Participating	Recipients	Payments (000 omitted)
Institutional:				
Skilled nursing homes	275	227	17,147	$31,044
Inpatient hospitals	209	148	41,179	19,180
Tuberculosis hospitals	2	2	270	284
Mental hospitals	4	4	3,303	5,090
Outpatient hospitals	209	148	77,548	2,849
Noninstitutional:				
Physicians	9,334	4,225	103,593	6,688
Prescribed drugs	1,933	1,263	(a)	11,755
Laboratory and X-ray	131	25	1,646	38
Home health and family planning	45	45	589	33
Medicare insurance premiums				4,150
Total			(b)	$81,111

[a]Not available; about 2.7 million prescriptions were filled.

[b]This column is not totaled because some persons received more than one service.

Administration of the Florida Medicaid program

The Florida State Department of Health and Rehabilitative Services administers the Medicaid program. The Bureau of Medical Services (part of the Division of Family Services) is the State agency responsible for overall administration and operation of the Medicaid program, including utilization review activities.

Utilization review activities are performed by (1) the Medicaid section of the bureau, which processes provider claims and conducts surveillance activities over Medicaid utilization, (2) the State's Jacksonville Data Center, which provides the computer services required for claims processing and utilization review, and (3) the utilization review committee functioning within the bureau.

CHAPTER 2

FLORIDA MEDICAID UTILIZATION REVIEW SYSTEM

In August 1970 the bureau initiated a formal utilization review program for Medicaid services. Previously utilization review consisted of manual and computer checks during claims processing.

The utilization review program envisioned, for all medical services, a system which would monitor and control overuse of the Medicaid program by providers (surveillance) and, to the extent possible, the quality and quantity of medical care for Medicaid recipients (utilization review). The system provides for:

1. Identification of providers who offer services and of recipients who receive services in excess of defined limits.

2. Review--including, when necessary, peer review--to determine whether providers overused the Medicaid program and whether recipients were provided with the appropriate quality and quantity of care.

3. Action, when necessary, to correct inappropriate care or use of the Medicaid program.

To implement the program the bureau established a utilization review committee composed of a physician, a pharmacist, a medical social worker, representatives from units that process claims from institutional and noninstitutional providers, and a representative from the data processing center.

The physician is a part-time employee who serves as committee chairman. The pharmacist is a full-time employee who manages and coordinates day-to-day activities of utilization reviews and prepares agendas for committee meetings. The committee meets once each month to monitor utilization review activities. Information about Medicaid utilization is made available to the committee primarily by the data processing center and by the claims-processing units. The committee may make investigations, request and/or conduct peer reviews, disallow specific claims, make recommendations related to policy changes, and disqualify providers.

The utilization review system comprises specific controls applicable to institutional and noninstitutional

services (see chs. 3 and 4) and general controls which are discussed in the following sections.

GENERAL CONTROLS APPLICABLE TO ALL SERVICES

The Bureau of Medical Services has established procedures for (1) ensuring that recipients and providers of medical services are eligible to participate in the program, (2) checking on the propriety of providers' claims for payment, and (3) controlling the extent of medical services provided.

Controls relating to eligibility

Each person eligible to participate in the Medicaid program is provided with an identification card showing his name and number. A provider must identify each recipient by number when billing the State for medical services.

Providers' participation in the program is voluntary. Providers, except for physicians, must enter into agreements with the State, signifying their willingness to follow State and Federal program regulations. To be eligible for payment from the State for services to Medicaid recipients, a provider must (1) meet State and Federal requirements, (2) be licensed, and (3) obtain from the State a Medicaid provider identification number, evidencing the State's determination of the provider's eligibility to participate in the Medicaid program.

Physicians do not enter into formal agreements with the State. To be paid by the State for services to Medicaid recipients, physicians must comply with the State's established claims-processing procedures and must be willing to accept payments which may be less than their usual and customary charges, as was the case during most of fiscal year 1971.

The data processing center compares providers' claims for payment for services to recipients with master eligibility files of identification numbers, to ensure that providers and recipients are eligible to participate in the Medicaid program.

The Division of Family Services validates eligibility for public assistance by means of a quality-control system. Under this system the division periodically selects samples of public assistance cases and reviews each case to evaluate the appropriateness of the eligibility determination and the amount of the payments.

The division reported that, for the period April through June 1971, its quality-control review of the (1) aid to families with dependent children program revealed that 7.2 percent of the families either were ineligible or had received incorrect payments and (2) aid to aged, blind, and disabled programs revealed an error rate of 8.6 percent. To the extent that medical services were furnished to ineligible recipients identified in the samples, inappropriate use was made of the Medicaid program.

Controls relating to propriety of provider claims

The processing of provider claims involves manual reviews and computer operations. Claims clerks manually review claims to (1) ensure that they are for compensable services and are complete and in proper format for computer processing and (2) select for further review those claims which deviate from established criteria or which are otherwise questionable. The data processing center processes claims for payment and provides reports to the utilization review committee.

Potential abuse or overuse of Medicaid might be identified first by claims clerks who select claims indicating questionable provider practices or procedures. Questionable claims which clerks cannot resolve are referred for review and resolution to an administrative assistant, a medical consultant, or the utilization review committee, depending on the reasons for questioning the claim.

The State's Jacksonville Data Center is the principal repository of Medicaid data. This data includes information about recipients, providers, and provider claims, including diagnoses, medical treatments and procedures, and costs. The center provides data processing services to the bureau. The center is capable of extracting recipient, provider, and claims data and of preparing reports having the desired content and format. This capability, however, was not used to develop recipient and provider profiles (histories of services received or provided).

Claims data is compared with master eligibility files in the data processing center to ensure that bills approved for payment are from eligible providers of services to recipients who have been issued identification numbers. The computer calculates the maximum amounts payable in accordance with payment formulas and reduces the amounts of claims for any overages. For claims for medical services within established limits, such as 45 days annually for inpatient hospital care, the computer determines the patients' remaining

entitlements and reduces the amounts of the claims that exceed the limits.

Claims processed for payment each month provide the bases for monthly surveillance and utilization review reports. These monthly reports list those providers and recipients who exceeded established exception limits. Those listed are not necessarily overusing Medicaid; the listings merely identify cases in which the need for additional review may be desirable.

The data processing center produces a number of reports for use by the utilization review committee. Examples of the contents of the principal reports follow.

--Average cost by type of service and place performed (doctor's office and inpatient or outpatient hospital).

--Pharmacies whose average prescription price exceeds the State-wide average prescription price by 50 cents.

--Ten highest paid providers.

--More than four visits to a patient, or nine medical procedures provided to a patient, by a physician(s) in a month.

--Claims for medical procedures used more than once for a patient on a specific day.

--Payments over $25 to a physician for one patient.

--Over 25 patients seen in a day by a physician.

--Lengths of hospital stays over 15 days.

Our discussion with the utilization review committee revealed that these data center reports were given scant attention because the information did not indicate deficiencies and was not sufficient to establish patterns or trends of normal or abnormal use of medical services. The committee indicated that, for the reports to be useful, they should contain considerable additional information to demonstrate that a patient's usage or a provider's practice, over a period of time, was consistently outside normal or acceptable limits.

Such information was not readily available, and the committee lacked sufficient personnel for its acquisition, analysis, and evaluation. Further, because of limited personnel

and computer resources, the data center had requested the committee to withhold requests for new reports.

Controls relating to extent of medical services provided

Some Medicaid medical services are limited to specific dollar amounts or, for hospital services, to a fixed number of days of care. Payment to providers is limited by a recipient's entitlement and also by monetary restrictions established by the State for specific services. Medical services are limited as follows:

Service	Limit for each recipient
Inpatient hospital	45 days a year
Outpatient hospital	$100 worth of services a year[a]
Physician visits	No limit
Laboratory and X-ray	$50 worth of services a year[a]
Prescribed drugs	$20 worth of drugs a month[a]
Nursing-home care	No limit
Home health care	No limit
Whole blood	First 3 pints, if unavailable from other sources

[a]May be increased if medical necessity is shown and if prior authorization is obtained.

Payments for medical services which are limited to specified amounts are controlled through a system of preauthorization of services and computer checks made during claims processing.

Payment criteria for medical care and services are as follows:

Service	Basis of payment to providers
Inpatient hospital	Reasonable cost
Outpatient hospital	Reasonable cost
Nursing home	$300 a month
Prescribed drugs	Cost plus a variable percentage markup, not to exceed customary reasonable charges
Physician	60 percent of usual and customary charges up to the 75th percentile, as developed from Florida Medical Association's 1968 Relative Value Studies[a]
Laboratory, X-ray, and home health care	Established fee, not to exceed payments made under Medicare for comparable service
Whole blood	Reasonable cost, not to exceed Medicare payments

[a]60 percent was in effect during most of fiscal year 1971 because the State lacked funds to pay 100 percent.

The bureau has established a system of preauthorization for medical services to Medicaid participants. Providers obtain authorization simply by telephoning (toll free) the nearest of the Medicaid terminals, which are located in all populous areas, and requesting transaction numbers. Terminals are connected to a computer system in Jacksonville, which permits immediate processing and the furnishing of transaction numbers.

As the request for a transaction number is processed the eligibility of both the recipient and the provider is confirmed by reference to recipient and provider numbers; remaining entitlement of the recipient for certain services, such as inpatient and outpatient hospital care, is calculated and recorded, and the estimated cost of the service being requested is established. The transaction number is recorded and used later in verifying the provider's claim. The bureau is able to maintain fiscal control and is assured that each transaction number issued involves a Medicaid recipient and a qualified provider.

Providers bill the State on the basis of their usual and customary charges. During claims-processing computer routines, bureau employees calculate the amount of payment appropriate for each claim and process payment documents on the basis of the lesser of the billed or calculated amounts.

Results obtained under general controls of utilization review system

Florida's utilization review system does not provide for the systematic accumulation of data showing (1) the reductions in Medicaid costs or other benefits resulting from utilization review or (2) a comparison of utilization review costs with the benefits provided.

Florida's system is, however, producing positive benefits. The claims-processing procedures were used to identify and reject claims, or portions of claims, that exceeded defined limits of services programmed into the computer. This resulted in reducing claims received from April 23 to August 23, 1971, for inpatient hospital services by $268,000 (from $7,247,000 to $6,979,000).

Also, during the period July 1970 through May 1971, claims for payment for skilled nursing-home care were reduced by $222,000. Additional reductions resulted from actions taken by the utilization review committee on claims questioned during the claims-processing activities and referred to the committee for resolution. The number of claims

reviewed and amounts disallowed by the utilization review committee during the period December 1970 through June 1971 were as follows:

Type of service	Claims examined	Amounts disallowed
Physician	688	$75,996
Hospital--inpatient	145	10,120
Hospital--outpatient	2	13
Pharmacy--inquiries	38	-
Pharmacy--audits	16	194
Laboratories	1	-

What effect these reductions or disallowances of claims have had on a provider's billing practice or on the amount of his subsequent claims is unknown. The committee had not accumulated information for measuring the broader effects of its actions.

The bureau had an information program which it used from time to time to enlist the cooperation of providers and to inform them of developments in Medicaid procedures and utilization review activities. For example, physicians were sent copies of the bureau's utilization review guidelines for review and comment. These guidelines explained the procedures that physicians should follow in billing for services to Medicaid recipients and called attention to a number of practices that could raise questions during review.

EVALUATION OF GENERAL CONTROLS

We believe that the bureau's preauthorization of services and its system for processing claims for payment of services provide adequate controls to ensure that payments are (1) for services rendered by eligible providers to eligible recipients, (2) for services of the kind and to the extent authorized under the program, and (3) limited to reasonable charges.

Although we identified some positive results stemming from these controls, weaknesses related to the reports produced by the data center (see p. 16) and to the absence of recipient and provider profiles indicated a need for improvement.

Utilization review of medical services generally is provider oriented. As a result deficiencies found and corrective actions taken by the utilization review committee

generally relate to claims by providers, especially physicians. We believe that increased attention to program utilization by recipients would enhance the benefits obtained from Florida's Medicaid utilization review system by providing a means of controlling the use of medical services by recipients.

CHAPTER 3

UTILIZATION REVIEW OF INSTITUTIONAL SERVICES

Of the $81 million paid by Florida for Medicaid services in fiscal year 1971, about $58 million, or 72 percent, was for institutional services. About $31 million was paid for nursing-home care, $19 million for hospital inpatient care, and $8 million for hospital outpatient services and inpatient care in mental and tuberculosis hospitals. (See p. 11.)

Claims-processing procedures and controls for tuberculosis and mental hospital services are similar to those described below for general inpatient hospital services. No utilization review program was established for patient care in tuberculosis and mental hospitals.

CONTROLS OVER NURSING-HOME SERVICES

Prior to January 1, 1972, the only level of nursing-home care provided under Medicaid was skilled nursing care.[1]

Section 1902(a)(26) of the Social Security Act, as amended, requires that State plans, effective July 1, 1969, provide for a regular program of medical review and evaluation of skilled nursing-home care. The Florida State plan provides for such a program. The program was started in February 1971 and was expanded in June 1971 under an agreement with the Florida Division of Health to perform medical reviews in about 84 nursing homes located in three of the State's 11 regions.

Medical reviews are coordinated by the bureau's institutional program supervisor. The reviews are conducted by teams staffed with a physician, a medical social worker, and other appropriate health personnel. The reviews are conducted as follows:

1. A medical social worker enters patient data on evaluation forms.

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[1] Pub. L. 92-223, approved December 28, 1971, provides that, effective January 1, 1972, care provided in intermediate-care facilities be included under the Medicaid program as an optional service. Such care previously was financed under the various cash assistance programs. Florida has adopted intermediate care as part of Medicaid.

2. A medical social worker, sometimes accompanied by a nurse, visits nursing homes to review patients' medical charts and records, observe patients (interview when feasible), and evaluate the findings.

3. The nurse and the medical social worker jointly recommend the level of care required by each patient.

4. The team physician reviews the evaluation form. If the physician concurs in the evaluation and recommendation, he signs the form and forwards it to the bureau. Questionable cases are reviewed further.

Copies of the evaluation forms are distributed to:

1. The Bureau of Medical Services.

2. The cognizant regional office, Division of Family Services, for action.

3. The nursing home.

During the period February through October 1971, medical reviews of 5,765 patients in skilled- and intermediate-care facilities showed that about 18 percent of the patients had been inappropriately placed for the levels of care needed.

The results of the medical reviews and our estimate of the additional monthly cost due to inappropriate placement of patients are summarized below.

Inappropriate placement	Number of patients	Estimated additional monthly cost
Patients in intermediate-care facilities who needed skilled nursing-home care	38	$-2,610
Patients in intermediate-care facilities who needed no nursing-home care	12	2,203
Patients in skilled nursing homes who needed only intermediate care	916	62,920
Patients in skilled nursing homes who needed no nursing-home care	78	19,726
Total	1,044	$82,239
Total number of medical reviews of patients in nursing homes	5,765	

Division of Family Services regional offices are required to act within 90 days on recommendations indicating a change in a patient's level of care. Possible actions include moving an intermediate-care patient to a skilled nursing home, moving a skilled-nursing-home-care patient to an intermediate nursing home, or removing a patient from nursing-home care.

Regional offices are required to report to the bureau those cases for which no corrective action has been taken. At the time of our review, no reports, or other evidence, were available at the bureau to show what corrective actions had been taken for the 1,044 patients who had been reported as inappropriately placed.

Utilization review activities include, besides medical reviews, surveillance of provider services through the manual and computer processing of claims for payment of services by the bureau's nursing home unit and the Jacksonville Data Center. The utilization review committee, however, does not review or evaluate nursing-home care.

In our opinion, the results of medical reviews of skilled nursing care should be made available to the utilization review committee. We believe that the information generated by these medical reviews--reports, findings, recommendations, and corrective actions--will enable the utilization review committee to identify nursing homes and physicians that overuse nursing-home care and to evaluate the adequacy of corrective actions taken.

In March 1972 the HEW Audit Agency reported on its review of skilled nursing-home services under Florida's Medicaid program. The part of the report dealing with utilization review concluded that the State needed to implement policies and procedures to ensure effective programs of medical review and utilization review of skilled nursing-home services.

The report commented on the need for

--continuing State-wide medical reviews and implementing medical review recommendations,

--coordinating medical reviews with utilization reviews to ensure compatibility and to avoid duplication,

--developing guidelines governing the activities of nursing-home utilization review committees,

--monitoring activities of nursing-home utilization review committees for compliance with Federal and State requirements, and

--expanding the Medicare intermediary's review of utilization review committee activities to achieve uniformity in review requirements and methods and to avoid duplication of effort and expense.

The State agency generally concurred in HEW's findings and recommendations.

CONTROLS OVER INPATIENT HOSPITAL CARE

The bureau's controls over inpatient hospital services include the preauthorization system described earlier (see p. 18) and the surveillance of provider services through the manual and computer processing of claims for payment of services. The utilization review committee discontinued reviewing claims involving excessive lengths of hospital stays in October 1971, due to a shortage of committee staff.

When a patient is discharged from a hospital, the provider secures a discharge transaction number from the bureau. Upon issuance of this number, the computer is programmed to print a Request for Payment form containing the provider's name, number, and address; patient's name, number, and county of residence; admission and discharge dates and transaction numbers; and the claim closing date. This form is sent to the provider, who completes it and returns it to the bureau for payment. Claims returned more than 100 days after the claim closing date are disallowed.

The bureau has not fully implemented several provisions of Florida's utilization review plan relating to hospital services. These provisions and our comments are summarized below.

--*Utilization review plans of institutions will be submitted to the bureau for approval.* We found that 47 percent of participating hospitals had not submitted utilization review plans to the bureau.

--*Providers will submit utilization review reports on Medicaid recipients along with provider claims.* We found that the bureau had not requested hospitals to submit routinely all utilization review reports involving Medicaid recipients. On several occasions the bureau had requested providers whose claims were in question to submit utilization review reports and medical records for specific recipients. In one instance

a patient was hospitalized for 25 days for observation, according to the admitting and discharge diagnosis. On the basis of information in the hospital's report, the bureau reduced the claim by 10 days.

--*The bureau will enter into an agreement with the Division of Health, State Department of Health and Rehabilitative Services, to monitor utilization review activities at participating hospitals.* The Florida Division of Health is the inspection and licensing agency for institutions providing health services and is responsible for monitoring utilization review activities of hospitals serving Medicare recipients. We found that the bureau had not entered into an agreement with the Division of Health for monitoring hospital utilization review activities relating to Medicaid recipients.

Division of Health officials told us that they did not monitor the activities of local utilization committees to ensure that utilization reviews actually were performed and that their principal concern was to ensure that each participating hospital had a utilization review plan. Bureau officials told us that, for this reason, they did not believe that an agreement with the Division of Health would be useful.

--*Hospital stays exceeding 15 days require authorization.* The bureau has not implemented this provision. About every 10 days--each billing cycle--the utilization review committee is furnished with a computer listing of patients having hospital stays exceeding 15 days. The committee has not reviewed the cases because the listing provides limited information and because the committee lacks sufficient staff to obtain the information needed to evaluate these cases.

At one time the bureau's claims clerks selected a sampling of hospital claims exceeding 15 days. For the sample cases the patients' diagnoses and lengths of stays were obtained from the providers' claims and were compared with published averages for lengths of stays for the same diagnoses. Claims of patients having stays exceeding the averages were referred to the utilization review committee. The committee obtained additional information, such as medical records and hospital review reports, involving these patients and decided upon the actions to be taken regarding the claims.

This comparison of sample cases was stopped in October 1971 because of the backlog of claims under utilization review. Only length-of-stay claims for physicians under special review and those claims specifically requested by the utilization review committee were being referred for reviews.

Reviews of excessive stay cases were time consuming because it was necessary to obtain additional information before evaluations could be made as to whether the lengths of stays were normal or excessive. A review of all the claims on the computer listings (a listing we examined contained 137 patients and 47 providers) would have increased the review time significantly because similar information would have been required to evaluate these cases.

The computer listing of patient hospital stays did not include patients whose stays were 15 days or less. Therefore no reviews were being made of the appropriateness of hospital stays of less than 16 days, even though the average length of stay for all Florida Medicaid patients was only about 7 days. The criterion (over 15 days) was unrelated to the normal time a patient could be expected to stay in the hospital for a specific illness.

In our opinion the average length of stay for patients having the same diagnosis is a good measure of a normal stay for that diagnosis. A determination as to whether a patient's stay is normal or excessive, therefore, should be related to the average length of stay for patients having the same diagnosis. This information was not shown on the computer listing. Also the computer listing covers one billing cycle--usually 10 days--which does not provide sufficient information to identify abnormal use by a provider, such as repeated claims involving excessive lengths of stay.

Controlling unnecessary hospital stays through a strong utilization review program would conserve patients' days of eligibility for care and would reduce Medicaid expenditures.

EVALUATION OF CONTROLS OVER INSTITUTIONAL SERVICES

The bureau's preauthorization of services and its system for processing claims for payment of services provide many effective controls over institutional-type services.

Medical reviews of nursing-home care have been effective in identifying patients inappropriately placed for the levels of care required. Results of these medical reviews and of

corrective actions taken should be made available to the utilization review committee to enable it to identify nursing homes and physicians overusing nursing-home care and to evaluate the adequacy of corrective actions taken.

The bureau has not implemented fully the following provisions of the utilization review plan relating to hospital services.

--Submission by hospitals of utilization review plans.

--Submission by hospitals of utilization review reports involving Medicaid recipients.

--Agreement with the Department of Health to monitor utilization review activities at hospitals.

--Authorization of hospital stays exceeding 15 days.

Selection of cases for evaluation of the need for continued care was limited to cases exceeding 15 days of hospitalization, without regard to patients' diagnoses or to other pertinent information.

CHAPTER 4

UTILIZATION REVIEW OF NONINSTITUTIONAL SERVICES

Of the $81 million paid by Florida for Medicaid services in fiscal year 1971, about $18.5 million, or 23 percent, was for physician services and prescribed drugs. About $6.7 million was paid to physicians for patients' visits, and $11.8 million was paid for 2.7 million prescriptions. (See p. 11.)

Laboratory and X-ray services, home health care, and family planning services costing $71,000 accounted for the remaining noninstitutional services. Other than controls to ensure the propriety of individual claims, there was no utilization review of these services.

CONTROLS OVER PHYSICIAN SERVICES

Because physician services are basic to all other medical services, the bureau devoted most of its utilization review resources to this area. Utilization review of physician services was performed by two consultant physicians and included, in addition to claims of physicians under special review, examination of questionable claims selected by claims clerks. Physician reviewers, on the basis of their expertise, examined information that was either included in a claim or requested from the claimant and approved, disapproved, or reduced the amount claimed.

Although the State plan proposed that services of the Florida Medical Association be secured for physician peer review, the bureau did not adopt this proposal. Bureau officials advised us that consultant physicians had not been hired to perform peer review because of a lack of resources.

The physician member of the utilization review committee reviews all claims (1) from physicians under special reviews because of histories of deficient claims, (2) involving questionable psychotherapy cases, (3) containing charges by a physician for more than one nursing-home visit a month for a patient, and (4) indicating overuse of the Medicaid program by providers or recipients. This review generally resolves questions of medical necessity and ensures that medical procedures identified in a provider's claim relate to the recipient's needs.

For example, a physician's claim for extensive laboratory work, including X-ray work, for a patient entering a

hospital might be questioned on the basis of medical necessity because this work normally is done at the hospital and is included in its daily rate. Likewise, treatment procedures that appear unrelated to a patient's diagnosis may be questioned. An attending physician or institution may be asked to submit additional justification in support of a questionable claim before it can be resolved.

A claim for five or more laboratory procedures or for three or more injections during one patient visit is referred by claims clerks to the bureau's administrative assistant for review. The claim is either approved for payment or sent to the utilization review committee for decision.

Claims are reviewed by a medical consultant if they involve (1) surgical charges in excess of $300, (2) surgical charges in excess of established maximums, (3) incidental or multiple-procedure surgery, (4) questionable illness or medical procedure codes and certain eye procedures, or (5) intensive care. The consultant may approve, disapprove, or reduce the amount of the claims.

The bureau does not maintain records of reviews by its administrative assistant and medical consultant. Therefore statistics on claims reviewed and approved or disapproved and amounts of reductions in the claims were not available.

The bureau does not use random-sampling techniques in selecting cases for utilization review of physician services. Furthermore the bureau has not developed a system for producing physician and patient profiles for use by the utilization review committee in relating a questionable claim to a physician's practice or to a patient's medical history. The underlying causes of improper claims may be overlooked or obscured because, in the review process, (1) there is no confrontation between reviewer and claimant about the facts in question and (2) the reviewer normally is not aware of how the circumstances involved in a specific claim relate to the physician's practice; that is, whether the procedure in question is usual or unusual for that physician.

CONTROLS OVER PRESCRIBED DRUGS

The bureau relies almost exclusively on its preauthorization system and on the computer system to control the prescribed-drug program. Pharmacy claims are reviewed manually only to the extent needed to prepare them for computer processing.

Each public assistance recipient is limited to $20 worth of drugs a month. This amount may be increased if medically necessary and if bureau approval is obtained. The bureau sends each public assistance recipient a monthly authorization, entitling him to obtain the $20 worth of prescribed drugs. The recipient gives the authorization form to a participating pharmacy of his selection. The pharmacy retains the authorization form to record and control the dollar amount of drugs dispensed. At the end of the month, the pharmacy submits, as its bill to the bureau, the completed authorization form--showing by code the drugs dispensed and their quantities and prices--and copies of the prescriptions.

Participating pharmacies enter into agreements with the bureau and are furnished with Medicaid rules, a list of drugs covered, and a payment schedule. The bureau pays only for those drugs which are (1) obtainable by prescription and (2) prescribed for therapeutic, rather than preventive, purposes. Preparations, such as vitamins, prescribed as tonics or dietary supplements are not covered. Physicians also have been advised of the restrictions in the drug program.

The bureau maintains a listing of drugs covered by code, and, during computer processing of pharmacy claims, the dispensed drugs are compared with this listing. Claims for nonlisted drugs are rejected. Also the computer is programmed to calculate the maximum allowable price for each drug and to compare this amount with the billed price. Payment is based on the lesser amount.

The maximum allowable price is based on the average wholesale price, plus a variable percentage markup. The percentage markup depends on the drug quantity dispensed in filling the prescription in relation to the drug quantity included in the wholesale package. For example, if 100 percent of the wholesale package is dispensed the percentage markup is 166 percent whereas the markup may go as high as 250 percent if only 25 percent or less of the wholesale package is dispensed. After prices for all drugs provided by a pharmacy to a recipient for a month have been calculated, the computer is programmed to total the amount payable to the pharmacy, which is reduced if it exceeds the recipient's monthly entitlement.

In a November 23, 1970, report to the Congress,[1] we pointed out that a drug-pricing method based on cost plus a percentage of cost (such as Florida's method) was contrary to HEW policy because it gave the pharmacies an incentive to sell higher cost drugs to obtain a greater profit.

In a January 1972 report on its review of pharmaceutical services provided under Florida's Medicaid program, the HEW Audit Agency pointed out that Florida's drug-pricing method did not meet Federal regulation objectives of paying prescription prices not exceeding the average price paid by the general public. State officials informed HEW that they were exploring the possibility of implementing a policy of cost plus a professional fee in paying for prescriptions.

The data processing center prepares a monthly report showing the total amount paid to each pharmacy, average prescription price, and amount by which this average price varies from the average price for all prescriptions paid for during the month. At one time the utilization review committee requested each pharmacy whose average prescription price exceeded the State average prescription price by $0.50 or $1 (depending upon total payment to the pharmacy) to explain the deviation. Few pharmacies responded to these requests. Those who did respond generally did not give information about their pricing structures that would adequately account for their deviations. The committee discontinued such inquiries.

For a time the bureau employed a pharmacist to perform onsite audits at participating pharmacies for the purpose of verifying the validity, propriety, and reasonableness of drug claims. During fiscal year 1971, 16 audits of randomly selected pharmacies were made with the following results.

--No discrepancies were found at nine of them.

--Twelve discrepancies, totaling $49.55, were found at six of them.

--Records to support $144.40 claimed were absent at one of them.

Refunds to the bureau amounted to $193.95. The bureau discontinued pharmacy audits in February 1971.

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[1]Report entitled "Controls Over Medicaid Drug Program in Ohio Need Improvement" (B-164031(3)).

In its January 1972 report, the HEW Audit Agency recommended that the State agency carry out a program of selective vendor reviews and that the basis for selecting vendors for review include consideration of volume of sales to Medicaid recipients. The Audit Agency recommended also that the State agency implement a statistical-sampling method for selecting drug claims for desk review, to ensure adequate coverage. The State agency concurred and stated that it would implement the recommendations as soon as sufficient staff was available.

EVALUATION OF CONTROLS OVER NONINSTITUTIONAL SERVICES

Florida has an effective utilization review system for physician services and prescribed drugs. The utilization review of these services can be improved by

- --developing histories of the use of the program by providers and recipients to assist in identifying the underlying causes of improper utilization,
- --using statistical-sampling techniques in selecting cases for review, and
- --keeping records on the results obtained by the different levels of utilization review.

CHAPTER 5

ADEQUACY OF STATE RESOURCES FOR UTILIZATION REVIEW

Bureau personnel generally agreed that the utilization review provisions of Florida's Medicaid plan had not been fully implemented.

According to bureau officials this was due, in part, to a lack of resources for utilization review activities. They stated that the lack of both professional and nonprofessional personnel had delayed implementation of several utilization review provisions of the State plan.

Bureau officials cited the following specific utilization review activities that were not being performed because of a lack of resources.

--Statistical sampling, in accordance with the State utilization review plan for both institutional and noninstitutional services.

--Monitoring of utilization review activities of institutional providers.

--Peer reviews of physician services by representatives of a recognized professional organization.

--Accumulating, analyzing, and evaluating recipient and provider data relating to trends of usage or patterns of practice which would permit the bureau to assess the medical areas needing the most utilization review attention and to determine the kind and amount of resources that should be devoted to the areas identified.

--Use of pertinent data made available to the utilization review committee by the data processing center.

In its budget request for fiscal year 1973, the bureau proposed 40 additional positions at an annual cost of $262,000. On the basis of our review of the descriptions of the proposed positions, it appears that nine (23 percent) of these positions were for the surveillance of Medicaid claims and that 28 (70 percent) were for utilization review.

At the conclusion of our review in December 1971, 58 (76 percent) of the bureau's authorized 76 positions were allocated to surveillance and only five (7 percent) were allocated to utilization review.

If the budget request is approved, annual personnel costs for utilization review activities will be increased from about $49,000 to about $251,000.

Although we have no basis for estimating the benefits to be derived from the employment of the additional personnel requested for fiscal year 1973, we believe that considerable improvements in utilization review activities could be achieved if the funds were obtained and used properly.

CHAPTER 6

EXTENT OF ASSISTANCE GIVEN BY HEW

The Florida Medicaid program began in January 1970. The development of its utilization review system appears to be primarily a result of the State's initiative, rather than a result of specific assistance by HEW.

The Associate Regional Commissioner, Medical Services Administration, HEW, told us that, before the State began its utilization review program, he had provided State officials with copies of other States' utilization review plans and had recommended a consultant to aid the State in preparing its utilization plan.

In October 1971 the HEW Audit Agency reported on its review of the administration of the Medicaid program in Florida. The part of the report dealing with utilization review concluded that the State agency needed to fully implement the utilization review requirements of the State plan to provide a systematic method of detecting and discouraging misuse of medical services by providers and recipients.

The report commented on the need for

--strengthening the utilization review committee staff with additional professional personnel,

--providing computerized recipient and provider profile reports for utilization review committee use,

--monitoring utilization review activities carried out by institutions and physician peer groups,

--complying with the requirement for prior authorization for hospital stays in excess of 15 days and the desirability of lowering the present criteria to 10 days, and

--developing review guidelines for claims examiners' use.

The bureau generally agreed with HEW's findings and recommendations and promised corrective action. At the time of our review, the bureau had requested funds for additional personnel. (See p. 33.) Also the bureau's claims examiners had been provided with specific guidelines for reviewing provider claims and for selecting claims for further review. The bureau had not implemented the other HEW recommendations.

In October 1971 HEW provided Florida with a model Medicaid management information system. The model system--the use of which is optional--is a result of HEW efforts to assist States in improving methods of administering their Medicaid programs and to correct certain problem areas existing in some States.

The objectives of the model system are to provide for effective processing, control, and payment of claims and to provide State management with necessary information for the planning and control of Medicaid programs.

The model system provides a broad "how to do it" framework, within which States can develop detailed systems specifications to meet requirements peculiar to their own systems. Within the model system six separate subsystems define and outline methods to be used for claims processing and payment, management and administrative reporting, and surveillance and utilization review.

The surveillance and utilization review subsystem is designed to detect misuse of the Medicaid program by providers and recipients. The system provides for (1) use of computer equipment to summarize claims data, to develop participant histories of services provided or received, and to screen and identify participants deviating by specified margins from prescribed parameters or norms of performance, (2) review and investigation of deviants to determine whether medical care or services are appropriate or whether misuse has occurred, and (3) use of appropriate corrective measures in cases involving misuse.

To test the adaptability of the model system to the specific needs of State Medicaid programs, HEW is implementing the system in Ohio. The general design of the model system is being tailored to a detailed design to meet Ohio's specific needs. HEW officials informed us that the system would be operational by about October 1, 1972.

At the conclusion of our fieldwork in December 1971, Florida's Bureau of Medical Services officials had not reviewed and evaluated HEW's model system. They said that those parts of the HEW system which could be adopted easily would be used.

CHAPTER 7

CONCLUSIONS AND RECOMMENDATIONS

CONCLUSIONS

Florida's preauthorization of services and its system for processing claims for payment of services provide adequate controls to ensure that payments (1) are for services rendered by eligible providers to eligible recipients, (2) are for services authorized under the program, and (3) do not exceed recipient entitlement or other payment limitations.

Although Florida's utilization review system is producing positive results, the system does not provide for the systematic accumulation of data showing (1) the reductions in Medicaid costs or other benefits resulting from the various levels of utilization review or (2) a comparison of utilization review costs with the benefits provided.

Medical reviews of nursing-home patients have been effective in identifying patients inappropriately placed for the levels of care required. We believe that the results of these reviews should be made available to the utilization review committee to enable it to identify nursing homes and physicians overusing nursing-home care and to evaluate the adequacy of corrective actions taken.

We believe that the criteria for selecting and reviewing cases requiring authorization for continued hospital care should be based on the relation of the patients' medical diagnoses and lengths of stays to the average length of stay for all patients having the same diagnosis.

We believe also that provider and recipient profiles should be developed to assist in identifying the underlying causes of improper uses.

Several provisions of the State's utilization review plan have not been fully implemented, principally because of the lack of resources available for utilization review activities. In its fiscal year 1973 budget the Bureau of Medical Services requested funds for 37 additional positions to be used in the surveillance and utilization review of Medicaid claims. Although we have no basis for estimating the benefits to be derived from the employment of the additional personnel, we believe that considerable improvement in the utilization review activity can be achieved if the funds are obtained and used properly.

The development and operation of Florida's utilization review system appear to be primarily a result of the State's initiative, rather than a result of specific assistance by HEW. HEW provided substantive assistance to the State in October 1971, however, when it provided Florida with the model Medicaid management information system.

At the conclusion of our fieldwork, State officials had not reviewed or evaluated HEW's model system. State officials said that they would use those parts of the model system that could be adopted easily. We believe that HEW's model system may offer Florida opportunities for improving its utilization review system and should be studied thoroughly.

RECOMMENDATIONS TO THE SECRETARY OF HEW

State officials were responsive to our suggestions and agreed to take actions to improve the utilization review system. We recommend that the Administrator of the Social and Rehabilitation Service, HEW, be required to assist the State and to monitor the State in its actions to

- --provide for the systematic accumulation of data enabling a comparison of the costs of utilization review with the benefits it provides and

- --study the HEW model system for the purpose of adopting design features offering opportunity for improvement.

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES
WASHINGTON, D.C. 20515

July 2, 1971

The Honorable Elmer B. Staats
Comptroller General of the
United States
Washington, D. C. 20548

My dear Mr. Staats:

In accordance with the Social Security Amendments of 1967, State plans for medical assistance (Medicaid) must provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan as may be necessary to safeguard against unnecessary utilization and to assure that payments are not in excess of reasonable charges.

A number of States which have adopted Medicaid programs have contracted with fiscal agents to perform utilization review functions as prescribed by section 1902(a)(30) of the Act. Nearly half of the States, however, do not use a fiscal agent in their program and some States--although they use fiscal agents to carry out some Medicaid functions--have retained responsibility for utilization review. We are aware that you are currently reviewing the activities of certain programs which involve fiscal agents.

I would appreciate it if the General Accounting Office would conduct an examination in the States of Florida, Maryland, Massachusetts and Missouri, which do not use fiscal agents for utilization review purposes and report to the Committee concerning the functioning of the utilization review systems in those States.

During your examination, I would suggest you inquire into such matters as:

1. Results being achieved under the utilization review systems.

2. Whether the selected States appear to have the necessary resources to carry out their utilization review program.

3. Whether instances of apparent excessive use of medical services are appropriately followed up and corrective action instituted.

4. The extent of assistance given by the Social and Rehabilitation Service of the Department of Health, Education, and Welfare to the States in the development of utilization review systems.

Any questions that may arise during the examination may be discussed with the Committee staff members.

Sincerely yours,

Wilbur D. Mills
Chairman

WDM/ff