REPORT TO THE CONGRESS

Control Needed Over Excessive Use Of Physician Services Provided Under The Medicaid Program In Kentucky

B-164031(3)

Social and Rehabilitation Service

Department of Health, Education, and Welfare

BY THE COMPTROLLER GENERAL OF THE UNITED STATES

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

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To the President of the Senate and the
Speaker of the House of Representatives

This is our report on control needed over excessive use of physician services provided under the Medicaid program in Kentucky. Medicaid is a grant-in-aid program administered at the Federal level by the Social and Rehabilitation Service, Department of Health, Education, and Welfare. Our review was made pursuant to the Budget and Accounting Act, 1921 (31 U.S.C. 53), and the Accounting and Auditing Act of 1950 (31 U.S.C. 67).

Copies of this report are being sent to the Director, Office of Management and Budget, and to the Secretary of Health, Education, and Welfare.

Elmer B. Staats

Comptroller General
of the United States

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ABBREVIATIONS

GAO General Accounting Office

HEW Department of Health, Education, and Welfare

COMPTROLLER GENERAL'S REPORT TO THE CONGRESS

CONTROL NEEDED OVER EXCESSIVE USE OF PHYSICIAN SERVICES PROVIDED UNDER THE MEDICAID PROGRAM IN KENTUCKY

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D I G E S T

WHY THE REVIEW WAS MADE

Under Medicaid, the Department of Health, Education, and Welfare (HEW) shares with the States the costs of providing medical care to individuals unable to pay. About $4.2 billion was spent under the program during fiscal year 1969; the Federal share was $2.2 billion.

The Social Security Amendments of 1967 require that the States safeguard against unnecessary use of medical services. Because Medicaid's spending for physician services, nationally, amounted to $505 million in fiscal year 1969, the General Accounting Office (GAO) reviewed this aspect of the program.

The percentage of Medicaid expenditures for physician services in Kentucky--where GAO made its review--was substantially higher than the nationwide average. Kentucky reported Medicaid expenditures for fiscal year 1969 of about $53 million; of this amount, about one fourth was for physician services.

FINDINGS AND CONCLUSIONS

HEW did not provide the States with guidelines to follow in evaluating the need, quality, quantity, or timeliness of medical services provided. HEW also did not adequately supervise or monitor, on a continuing basis, Kentucky's evaluation of medical services provided.

Although Kentucky had established some procedures for reviewing physician services and had identified instances of physician services being misused, more effective action by the State was needed to curb excesses in using the program. (See p. 11.)

Kentucky formed a committee in November 1968 to review the Medicaid services. At the time of GAO's fieldwork (July 1969 to Apr. 1970), the committee was understaffed and had directed its efforts primarily to reviewing pharmacy services; relatively little attention had been given to physician services, which accounted for almost one fourth of the State's Medicaid costs. (See p. 9.)

GAO selected 100 Medicaid recipients' cases to review the use of physician services. GAO's selection was made from recipients identified by the State's review committee as having received large quantities of drugs. Interviews with the physicians who attended these recipients or reviews of correspondence between the State and prescribing physicians showed that:

--84 recipients received an excessive number of prescriptions and were overusing physician services. They received an average of 18 prescriptions a month at an average monthly cost of $47.

--Of the 84 recipients, 62 were averaging five visits a month to different physicians at an average monthly cost of $33.

For example one recipient obtained services 170 times during a 14-month period, or about once every 3 days, from six different physicians. He sometimes visited two physicians on the same day. During one 3-month period, Medicaid paid for 50 prescriptions for this recipient. (See p. 16.)

Although Kentucky had taken steps to advise physicians on matters concerning the quantity and quality of medical care under the program, the physicians visited by GAO generally expressed the view that they--and the recipients--had not been adequately informed by the State about the purposes and uses of Medicaid. (See p. 17.)

An obstacle to examining and evaluating the quantity and/or frequency of physician services is the HEW regulation--adopted by Kentucky--which allows providers of service to submit bills for payment under Medicaid up to 2 years after the services are provided. (See p. 12.)

It appeared to GAO that staffing limitations at both the Federal and State levels contributed to these problems and that better monitoring of Kentucky's activities by HEW would have assisted in their solution. (See pp. 20 to 23.)

RECOMMENDATIONS OR SUGGESTIONS

HEW should

--provide the States with guidelines to assist in effectively reviewing the use of physician services, including limits as to the quantity and/or frequency of medical services,

--increase its monitoring of the States' evaluations of physician services, and

--reduce the 2-year period during which providers may bill for services. (See p. 23.)

AGENCY ACTIONS AND UNRESOLVED ISSUES

HEW said that guidelines for evaluating the use of medical services had been prepared in draft form and it was hoped that such would be issued in the near future. In addition, contracts had been awarded to Colorado, Oklahoma, Rhode Island, and West Virginia for a pilot surveillance and review program. (See p. 24.)

HEW has (1) provided for an increase in the Medicaid program staff, (2) agreed to increase its monitoring of State evaluations of physician services, and (3) agreed to shortly institute a closer monitoring and liaison program with each individual State agency. HEW feels that this will provide for more frequent visits and detailed reviews of State operations. Kentucky has advised HEW that it is adding to the staff of its Medicaid program as rapidly as it can. (See pp. 24 and 25.)

HEW said that it was in the process of amending its regulations to require submission of bills within 6 months of the date the services were provided rather than 2 years. Kentucky put such a limitation into effect on October 1, 1970. (See p. 25.)

GAO believes that these actions will help to improve the effectiveness of evaluations of the use of physician services.

MATTERS FOR CONSIDERATION BY THE CONGRESS

GAO is sending this report to the Congress because of congressional interest in the Medicaid and other health-related programs.

CHAPTER 1

INTRODUCTION

The General Accounting Office has reviewed the adequacy of controls over the use of physician services under Kentucky's Medicaid program. The Medicaid program--authorized by 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 participates in costs incurred by the States in providing medical assistance to individuals who are unable to pay for such care. Medicaid is administered at the Federal level by the Social and Rehabilitation Service of the Department of Health, Education, and Welfare.

Since inception of the program in January 1966, the act has required State Medicaid programs to provide inpatient hospital services, outpatient hospital services, laboratory and X-ray services, skilled nursing home services, and physician services. Additional services, such as dental care and prescribed drugs, may be included in a State's Medicaid program if the State so chooses.

As of December 1970, 48 States and the District of Columbia, Guam, Puerto Rico, and the Virgin Islands had adopted Medicaid programs. The Federal Government pays from 50 to 83 percent (depending on the per capita income of the States) of the costs incurred by States in providing medical services under their Medicaid programs. For fiscal year 1969, the States and jurisdictions then having Medicaid programs reported expenditures of about $4.2 billion of which about $2.2 billion represented the Federal share. About $505 million of the total Medicaid expenditures was for physician services.

Medicaid expenditures in Kentucky for fiscal year 1969 were about $53 million, of which the Federal share was about $43 million. We reviewed the controls over Medicaid expenditures for physician services in Kentucky because we noted that expenditures for physician services represented 23 percent of the State's total Medicaid expenditures compared to a nationwide average of only 13 percent. The scope of our review is described on page 26.

ADMINISTRATION OF MEDICAID PROGRAM

At the Federal level, the Secretary of HEW has delegated the responsibility for administering the Medicaid program to the Administrator of the Social and Rehabilitation Service. Authority to approve grants for State Medicaid programs has been further delegated to the Regional Commissioners of the Service who are responsible for administering the field activities of the program through HEW's 10 regional offices.

Under the Social Security Act, the States have the primary responsibility for initiating and administering the Medicaid program. The nature and scope of a State's Medicaid program are contained in a State plan which, after approval by a Regional Commissioner, provides the basis for Federal grants to the State. Also, the Regional Commissioners are responsible for determining whether the State programs are being administered in accordance with Federal requirements and the provisions of the State's approved plan. Supplement D of HEW's Handbook of Public Assistance Administration and the Service's program regulations provide States with Federal guidelines and instructions for administering the Medicaid program.

At the time of our fieldwork, the HEW regional office at Charlottesville, Virginia, provided general administrative direction for medical assistance programs in the District of Columbia, Kentucky, Maryland, North Carolina, Puerto Rico, Virginia, the Virgin Islands, and West Virginia.

The HEW Audit Agency is responsible for audits of the manner in which Federal responsibilities relative to State Medicaid programs are being discharged. The Audit Agency has performed--and is currently performing--a number of reviews of Medicaid activities. The Audit Agency was reviewing certain aspects of the Kentucky Medicaid program at about the same time we began our review. The Audit Agency did not review the utilization of physician services under the program. Also, State auditors had made a review of the eligibility of persons to receive Medicaid benefits but had not examined into the services provided to recipients.

A listing of principal HEW officials having responsibility for the administration of activities discussed in this report is included as appendix III.

PERSONS ELIGIBLE FOR MEDICAID

Persons receiving public assistance payments under other titles[1] of the Social Security Act are entitled to benefits under the Medicaid program. Persons whose income or other financial resources exceed standards set by the States to qualify for public assistance programs but are not sufficient to meet the costs of necessary medical care are, at the option of the States, also entitled to benefits under the Medicaid program. Those persons receiving public assistance payments are generally referred to as categorically needy persons whereas other eligible individuals are generally referred to as medically needy persons.

MEDICAID PROGRAM IN KENTUCKY

The Kentucky Medicaid program began in July 1966. The State Department of Economic Security was designated as the single State agency responsible for administering the program. In addition to furnishing the basic services required by the act (see p. 4), the Kentucky Medicaid program provides prescribed drugs, home health care services, dental services, mental and tuberculosis hospital services, and community mental health center services.

In carrying out its responsibilities, the Department of Economic Security has entered into an agreement with the State Department of Health to carry out the medical aspects of the program. The agreement provides that the Department of Health is to:

--Develop and maintain policies, procedures, and instructions for the operation of the medical aspects of the program.

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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 other titles.

--Administer medical care activities.

--Evaluate the medical aspects of the program.

Medicaid services in Kentucky are provided to both the categorically and the medically needy. According to a State program official, as of April 1970 about 210,000 categorically needy persons and 110,000 medically needy persons were eligible for Medicaid benefits.

REQUIREMENTS FOR UTILIZATION REVIEW

The act establishing the Medicaid program did not contain a requirement that procedures be provided to safeguard against unnecessary utilization of services. Utilization refers to the need, quality, quantity, or timeliness of medical services provided. The Social Security Amendments of 1967 required that, effective April 1, 1968, State Medicaid plans 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 of such care and services and to assure that payments (including payments for any drugs provided under the plan) are not in excess of reasonable charges consistent with efficiency, economy, and quality of care."

On February 9, 1970, the staff of the Senate Committee on Finance issued to the Committee a report entitled "Medicare And Medicaid; Problems, Issues, And Alternatives." The report stated that the Medicaid program was in serious financial trouble due to heavy utilization and that the program was adversely affecting health care costs. The report stated that, although there was a growing awareness among many physicians of the need for the profession to effectively police and discipline itself, performance had been spotty and isolated.

HEW implementation

To implement the 1967 amendments relating to utilization of services, 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 must 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 administration of the program. Kentucky has established such a unit.

The Service's regulation, however, does not specify the manner in which these utilization reviews are to be made, nor does it establish minimum requirements as to what a utilization review plan is to provide for.

In an April 1969 draft of guidelines relating to utilization reviews, which was sent to the HEW regions for comment, the Social and Rehabilitation Service stated that institutional services should be reviewed for such things as necessity of admission and duration of stay and that noninstitutional services should be subject to surveillance to ensure that services rendered are based on actual need and that frequency of care and service is appropriate to that need. Also the draft stated that a utilization review should include (1) a method of reviewing the need for medical services before the services are provided and (2) a review to determine the propriety of individual claims and to accumulate, analyze, and evaluate claims data to identify patterns and trends of normal and abnormal utilization of services.

At the close of our fieldwork in April 1970, the States had not been provided with any guidelines for implementing the March 1969 regulation.

State implementation

A utilization review committee was formed in the Kentucky Department of Health in November 1968. At that time, the committee consisted of a physician (in charge) and a registered nurse. Subsequently, the committee was expanded to include a statistician and three clerks; however, the physician left the committee in June 1969 and had not been replaced at the time we completed our fieldwork in April 1970. This review committee was responsible for establishing utilization criteria and for making utilization reviews of all types of services provided under the State's Medicaid program.

In its comments on a draft of this report, the HEW regional office informed the HEW central office that the Advisory Council for Medical Assistance (a professional organization) was actively assisting the State in the

establishment of an effective utilization review program and that its recommendations providing for systematic surveillance of program effectiveness were being implemented.

CHAPTER 2

CONTROL NEEDED OVER EXCESSIVE USE OF PHYSICIAN SERVICES

Our review revealed that HEW had not provided the State with guidelines for use in implementing the requirement for utilization reviews of physician services nor had HEW adequately monitored Kentucky's utilization review activities. Although Kentucky had established some procedures for utilization reviews of physician services and had identified instances of overutilization of physician services, the State had not taken effective action to curb overutilization. Our review showed instances in which physicians were paid under the Medicaid program for services that were not provided and in which recipients were provided with excessive medical services. In addition, the quality of care being provided by some physicians did not meet standards acceptable to the State's professional staff in the Department of Health.

The following sections contain our comments on the (1) progress by Kentucky in developing a system of utilization review, (2) guidance and monitoring provided by HEW, and (3) need for further improvements in these areas.

NEED FOR EFFECTIVE PROCEDURES TO AVOID OVERUTILIZATION OF PHYSICIAN SERVICES

During the first 6 months of its existence, Kentucky's utilization review committee placed emphasis on reviewing the use of pharmacy services. In January 1969 the committee began to obtain--from the Department of Health's data processing unit--computer printouts of payments to physicians. In analyzing this information, the committee looked for unusual charges, such as charges for (1) several or all members of a family at one visit, (2) apparent excessive laboratory procedures, or (3) more than one visit involving the same recipient in 1 day.

The committee identified 12 physicians to whom excessive payments appeared to have been made. For example, the

committee advised one physician that records of his billings indicated that he had been paid a total of $80 for two office visits made by each of eight recipients on the same date. After the committee requested an explanation of these apparently excessive charges, the physician refunded half of the money to the State. In total the State obtained refunds amounting to $5,500 from seven of the 12 physicians. A detailed review of the charges made by other physicians indicated that in some cases the questioned billings were justified.

Also the committee's review indicated that duplicate payments were a major problem. In November 1969 the committee requested the Department of Health's data processing unit to supply it with another computer printout which would facilitate the identification of duplicate payments. Using this printout, the committee identified about 900 physicians who appeared to have received duplicate payments, and, as of April 1, 1970, the State had obtained refunds of about $12,000 from about 200 of these physicians.

HEW regulations allow providers of medical services to submit Medicaid bills up to 2 years after the services are provided. Kentucky adopted this 2-year period for its Medicaid program. This billing period creates problems in making timely and effective utilization reviews. For example, all duplicate payments made during a 2-year period cannot be identified unless all bills submitted during the period are reviewed. Also, billings could be so old as to be forgotten by the recipient if he is requested to verify billing data.

Regarding the necessity of the 2-year billing period, the State director of medical services agreed with us that effective utilization reviews could not be achieved under such a billing period and informed us that the State would revise its program to correct the situation. By letter dated September 8, 1970, the Commissioner, Department of Economic Security, advised HEW that effective October 1, 1970, the State would require all providers of service to submit their bills within 6 months of the date of service. In our opinion, this should aid the State in making more timely and meaningful utilization reviews of services provided under the Medicaid program.

The committee conducted field investigations of circumstances relating to physicians' services where it appeared to the committee that (1) charges had been made for several or all members of a family although only one or two members of the family had actually been treated and (2) the physicians had charged for seemingly unnecessary follow-up visits in cases of minor illness. For example, the committee investigated four physicians--of the initial 12 identified as possibly having received excessive payments--and found that three of them had billed and received payment under the program for recipients to whom they had not rendered any service. These three physicians were suspended by the State from participation in its Medicaid program. One of these physicians subsequently refunded $2,395 received through erroneous billings and he was reinstated in the program. The cases of the two other physicians were referred to the Kentucky attorney general.

In the document suspending one of these physicians, whose case was subsequently referred to the attorney general, the Commissioner, Department of Economic Security, stated that available data indicated that the physician:

> "*** has billed the program for physician's services when an actual physician/patient contact was not had; that he has prescribed drugs for individuals without medical examination of the person for whom the prescriptive drug was intended; and that the numerous prescriptions written for voluminous drugs for particular individuals was not warranted."

In June 1970 an indictment brought against this physician was dismissed by the circuit court. The order dismissing the case stated that the State law under which the physician was indicted did not state a public offense with which the physician could be charged and that the circuit court had no jurisdiction under the circumstances of the case. The Commissioner, Department of Economic Security, informed us that the State intended to continue the suspension of this physician from program participation. Final disposition of the other case referred to the attorney general was pending at the completion of our fieldwork.

Subsequent to the referral of these two cases to the Kentucky attorney general, two additional physicians were identified by the State as having billed and been paid under the program for services rendered to recipients although the physicians had not rendered any services. The State did not suspend these physicians; however, the State obtained refunds totaling about $3,000 from one of the physicians. The Commissioner, Department of Economic Security, advised us that he would defer action against these physicians pending the disposition of both cases referred to the attorney general.

GAO use of information developed during utilization review of pharmacy services

At the time we began our fieldwork in July 1969, Kentucky had not developed recipient profiles[1] for reviewing the use of physician services. However, in its utilization review of pharmacy services, the committee had assembled certain information useful to us in evaluating the utilization of physician services.

In its review of pharmacy services, the committee obtained printouts for the period December 1, 1968, through September 30, 1969, listing all recipients (1) for whom 15 or more prescriptions had been provided in any month or (2) for whom the State had paid for 30 or more prescriptions in any month. The printouts listed the names of 1,563 recipients. The committee selected 742 of these recipients and requested the prescribing physicians to comment on the propriety of the volume of medication which had been provided to these recipients. The committee received responses for 122 of these cases. The committee provided the Department of Economic Security with the names of recipients who--according to the prescribing physicians--were overutilizing services provided under the program. The department instructed its local welfare offices to counsel the recipients on the proper use of services under the program; however, in February 1970 the Department of Health advised the Department of Economic Security that the counseling was not effective in curbing overutilization and that other controls would be needed.

For our review of the utilization of physician services, we selected 100 cases--consisting of 56 of the 122 cases in which the committee had received responses and 44 of the 620 cases in which the committee had not received responses from the prescribing physicians. With the assistance of

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[1] A recipient profile is a historical record of payments for covered medical services to be used as a guide in evaluating the reasonableness of the amounts of current billings by the providers of such services and the frequency and appropriateness of the use of the program by the recipient.

professional employees of the Department of Health, we reviewed the responses received by the committee for the 56 cases and discussed 40 of the other 44 cases with the prescribing physicians. We were unable to obtain physician comments for four of the recipients because the physicians were not available to meet with us.

In the 96 cases examined by us, the comments of the prescribing physicians indicated that the medical services received by 12 recipients were appropriate but that an excessive number of prescriptions and other physician services had been provided for 84 of the recipients. These 84 recipients had been provided an average of 18 prescriptions a month at an average monthly cost of $47.

With respect to other physician services, we were able to obtain data for only 62 of the 84 recipients. These 62 recipients were, on the average, visiting five different physicians each month at an average monthly cost of $33. Following is an example of one recipient who, according to the physicians, was overutilizing services under the program.

> The recipient obtained medical services from physicians 170 times during a 14-month period, or about once every 3 days. The recipient obtained these services from six different physicians during this period. He sometimes visited two physicians on the same day, and, during one 3-month period, the State paid for 50 prescriptions for this recipient. State records contained the comment from the physician who treated this patient most often that he had prescribed only 10 of the 50 prescriptions.

In this case--and in 16 other cases involving eight other physicians--the physicians expressed their opinion that recipients found to be obtaining excessive amounts of drugs should be locked-in to one physician and one pharmacy.

The February 1970 report of the staff of the Senate Committee on Finance entitled "Medicare And Medicaid; Problems, Issues, And Alternatives" recommended that States require the designation of a "primary physician" in cases where overuse of physician services is detected. In a letter to

HEW dated September 8, 1970, the Commissioner, Kentucky Department of Economic Security, stated that lock-in plans are being considered in instances in which overutilization appears to be evidenced.

The following table (1) summarizes information pertaining to physician services provided to the 62 recipients for whom we were able to obtain sufficient data and who, in the opinion of the physicians, were overutilizing services under the program and (2) provides examples of individual cases of overutilization.

Summary of information pertaining to all 62 recipients

Number of recipients	Average number per recipient of: Months of physician services reviewed	Visits a month to a physician	Prescriptions a month	Average monthly cost of physician services and prescriptions per recipient
62	10.6	5	18	$80

Summary of overutilization of physician services by some of these 62 recipients

Recipient	Number of months of physician services reviewed	Average number of visits a month to a physician	Average number of prescriptions a month	Average monthly cost of physician services and prescriptions
A	15	9	21	$113
B	12	7	18	98
C	15	8	19	90
D	14	7	18	97
E	9	4	24	78
F	13	5	30	100
G	9	4	22	79
H	14	7	47	197
I	15	7	12	84

Our review showed that, although the State had supplied manuals and explanatory materials to physicians and had established an advisory committee of physicians to advise State Medicaid officials on matters concerning the quantity and quality of medical care under the program, the physi-

cians visited by us generally expressed the view that providers and recipients had not been adequately informed by the State about the purposes and uses of the Medicaid program. We believe that better program monitoring by HEW would have helped to identify the need for person-to-person communication between program officials and participating physicians.

As stated earlier (see p. 6), the Kentucky Department of Health is responsible for evaluating the medical aspects of the State's Medicaid program. Our review prompted Department of Health professional personnel to visit 31 participating physicians for this purpose. On the basis of these visits, the Department of Health professional staff concluded that (1) one physician appeared too senile to practice medicine, (2) the quality of care provided by another physician was questionable because the physician's office was dirty and not properly equipped, and (3) the quality of care provided by another physician was questionable because he frequently prescribed drugs that affected the central nervous system for his Medicaid patients whom he did not always examine but for whom he billed the State for office visits.

The first physician advised the State that he was retiring from the practice of medicine, the second physician was advised by the State to correct the inadequacies which were observed, and, the third physician was suspended by the State from program participation.

State use of recipient profiles

In October 1969 Kentucky began to routinely develop recipient profiles--information relating to physician services and drugs provided to each Medicaid recipient. In January 1970 the State forwarded to each recipient--and to the appropriate local welfare office--a computer printout showing the medical services paid for on the recipient's behalf by the State during the preceding 3 months. Recipients were requested to contact their local welfare office if the information on the printout was not consistent with their recollection of the services provided to them. The local welfare offices were told to report any inconsistencies brought to their attention by recipients.

As of April 1, 1970, the State office had received no feedback from either the recipients or the welfare offices.

The State's program records, however, contained evidence of overutilization of services under the program and indicated to us that the local welfare offices and/or recipients probably were not properly instructed on how to interpret the printouts.

A State official visited a county welfare office in April 1970 to ascertain the reason for the lack of feedback. Several social workers advised the State official that, although the Department of Economic Security was relying on them to assist in program monitoring, they had not been instructed on how to use the information on the printout nor had they been provided with any guidelines on how to identify overutilization. In our opinion, such recipient profiles should either be evaluated by professional medical personnel or, if social workers are responsible for reviewing profiles, they should be furnished with explicit criteria as to what constitutes questionable utilization and, in those cases, the action to be taken.

We were informed by HEW that certain other States had established quantity and/or frequency limits (parameters) for use in evaluating the reasonableness of physician services. When these parameters are exceeded, the computer prints out a "physician exception report" which contains detailed information concerning a physician and/or recipient. This report is analyzed by the program physician who determines whether services under the program are being overutilized.

For example, under one State's Medicaid program, whenever a provider's total monthly billings exceed $400, the computer system will printout, for review by management officials, a report containing detailed information relating to these services. Similarly, various other parameters have been established for providers and recipients. Whenever any of these parameters are exceeded, the computer system provides a report for review by management officials.

We believe that the development and use of parameters similar to those used in other States--giving recognition to local geographic and socioeconomic factors--would be beneficial in controlling utilization of services under the Kentucky Medicaid program.

NEED FOR IMPROVED MONITORING OF UTILIZATION REVIEW ACTIVITIES

HEW needs to improve its monitoring of utilization review activities of State agencies to ascertain whether they are effective. We believe that better monitoring, including follow-up of problems noted, of Kentucky's utilization review activities would have shown a need for the State to

--establish parameters for medical services provided for use in reviewing program utilization,

--reduce the time allowed for providers to submit bills for services provided, and

--take action to control further program participation in cases in which overutilization was identified.

Although the State of Kentucky had established procedures for utilization review of physician services and had identified instances of overutilization of physician services, we found that the State had not taken effective action to curb overutilization. We believe that the overutilization of services could have been detected and corrected timely had HEW effectively monitored the State's utilization review activities.

The regional Social and Rehabilitation Service staff for medical services was responsible for Federal administration of the Medicaid program in Kentucky--as well as four other States, the District of Columbia, Puerto Rico, and the Virgin Islands--at the time of our fieldwork. The professional staff consisted of an Associate Regional Commissioner and two medical care specialists. The staff's responsibilities included (1) the promotion and general oversight of the provision of Medicaid services and (2) the provision of guidance to State and local agencies in the administration and evaluation of Medicaid programs. Effective July 1, 1970, the regional offices were assigned the primary responsibility for evaluation of State Medicaid programs. Evaluation of the States' programs had previously been made chiefly by officials of the HEW central office with assistance from the regional offices.

We reviewed the records of the regional medical services staff relating to utilization review activities and found only one report--dated April 1969--relating to a visit to Kentucky. Also, representatives of the HEW regional office at Charlottesville, Virginia, assisted the HEW central office in a program review and evaluation in Kentucky during the period February 5 to 9, 1968.

The April 1969 report was the result of a review requested by the Commissioner, Kentucky Department of Economic Security. In the report to the State, regional officials stated that (1) parameters had not been established that would help program officials distinguish between normal and abnormal patterns of medical practice and (2) systematic documented procedures had not been developed for resolving questions of abuses under the program in cases where overutilization was indicated. Although the report showed that HEW regional representatives were aware of some of the weaknesses in the Kentucky utilization review program, they did not require the State to implement effective utilization review procedures. HEW regional officials advised us that staffing limitations prevented them from adequately monitoring the Medicaid program in the entire region, including following up to see that problem areas are corrected.

The program review and evaluation report issued as a result of the February 1968 examination discussed some of the same types of program weaknesses as are discussed in this report. For example, the report indicated a need for more detailed study and planning by the State concerning the adoption of utilization control techniques such as the establishment of parameters for medical services provided.

Also an HEW task force's November 1969 interim report on Medicaid and related programs indicated a need for substantial improvement in HEW's monitoring of the States' administration of the Medicaid program. The task force reported that the Federal role had been primarily one of passive monitoring and that such a role was detrimental to efficient and economical management of the program. The task force noted that it had not found any State having an effective system of utilization review and concluded that a strong, specific, and comprehensive Federal policy needed

to be developed to assist States in establishing and maintaining effective Medicaid programs.

Following a reorganization of the Medical Services Administration, Social and Rehabilitation Service, in March 1970, HEW provided for a total increase of about 125 staff positions in the Administration's Washington and field offices. The reorganization and employment of the additional personnel should enable HEW to provide more effective monitoring of Medicaid programs and greater assistance to State agencies in the administration of their Medicaid programs.

CONCLUSIONS

The Social Security Amendments of 1967 required that, effective April 1, 1968, States having Medicaid programs must provide safeguards against unnecessary program utilization. Although utilization review activities conducted by Kentucky have identified instances of overutilization of physician services, the State had not established an effective utilization review system for physician services.

We believe that the problems experienced in establishing and implementing utilization review procedures are attributable principally to HEW's not having defined the type of reviews needed for the various services and not having provided adequate assistance to the States in developing effective utilization review systems. Existing HEW regulations only direct that such systems be implemented but do not provide guidelines to the States as to how a system should be developed. Although a draft of guidelines relating to utilization review was forwarded for comments to HEW regions in April 1969, such guidelines had not been finalized and issued at the close of our fieldwork 1 year later.

We believe that HEW needs to furnish States with information on methods for reviewing and controlling the utilization of the various medical services provided. Such direction might include model systems for reviewing the major categories of services provided and the manner in which professional medical groups can be used to assist the States in controlling utilization. On the basis of our review in Kentucky, we believe that HEW should assist the States in establishing parameters for medical services provided to help identify potential overutilization of services. We believe also that the effectiveness of utilization review activities would be increased if HEW reduced the 2-year period now allowed for submitting bills for services provided under Medicaid.

RECOMMENDATIONS TO THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE

We recommend, therefore, that HEW, through the Social and Rehabilitation Service, (1) provide the States with guidelines to assist in effectively reviewing the use of

physician services, including limits as to the quantity and/or frequency of medical services, (2) increase its monitoring of the States' evaluations of physician services, and (3) reduce the 2-year period during which providers may bill for services.

AGENCY COMMENTS AND ACTIONS

In a letter dated October 8, 1970, the Assistant Secretary, Comptroller, HEW, furnished us with HEW's comments on our findings and recommendations, including its evaluation of comments obtained from officials of the Kentucky Department of Economic Security. (See apps. I and II.) HEW stated that our report presented a factual picture of the situation in Kentucky regarding opportunities to improve the utilization review of physician services and advised us that the State officials agreed, in general, with our findings.

Regarding our recommendation that utilization review guidelines be established, HEW replied that such guidelines had been prepared in draft form and it was hoped that such would be issued in the near future. In addition, HEW informed us that contracts had been awarded to four States--Colorado, Oklahoma, Rhode Island, and West Virginia--for the implementation of a pilot medical surveillance and utilization review program. HEW hopes that the results thus obtained will strengthen the ability of States to monitor, plan, and administer the Medicaid program.

In his letter to HEW commenting on a draft of this report, the Commissioner, Kentucky Department of Economic Security, stated that efforts to improve the control of overutilization of physician services--and other phases of the program--were continuing and personnel to be utilized in this effort were being added as rapidly as qualified persons could be attracted to the staff. The Commissioner added that, during calendar year 1970, there had been special emphasis placed on recipient profiles from the standpoint of both physician visits and drug utilization in an effort to identify heavy users. He stated that field workers are assigned to examine, by personal contact, the causes of what appear to be excessive use of the program services and that the field workers' reports are reviewed by appropriate professional teams and recommended action is followed.

HEW agreed with our recommendation that action be taken to provide for increased monitoring of the States' utilization reviews of physician services. HEW stated that it planned to shortly institute a closer monitoring and liaison program with each individual State agency by each of its regional offices along with the cooperation of the Washington central office. Under this new program, HEW plans to have a closer relationship with the State agencies along with more frequent visits and detailed reviews of State operations. HEW stated that it would continue to evaluate the adequacy of its guidelines in the light of information brought to its attention through its continuous monitoring of State programs and would make any needed adjustments.

HEW agreed also with our recommendation that it revise its regulations to reduce the 2-year period during which providers may bill for services provided under Medicaid. HEW advised us that it was in the process of amending its regulations to reduce the 2-year limitation period to a 6-month period for all services. Kentucky put such a limitation into effect on October 1, 1970.

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We believe that the actions promised by HEW, if properly implemented, will help to improve the effectiveness of the utilization review of physician services provided under the Medicaid program.

CHAPTER 3

SCOPE OF REVIEW

Our review was directed toward an evaluation of the controls exercised by HEW and by Kentucky over the utilization of physician services paid for under the Kentucky Medicaid program. We reviewed this aspect of the Medicaid program at State offices in Frankfort, Kentucky; at the HEW regional office at Charlottesville, Virginia; and at the HEW headquarters in Washington, D.C.

We examined pertinent legislation and Federal regulations, Social and Rehabilitation Service program policies and directives relating to the review and control of the utilization of physician services, and records and related data concerning the utilization of physician services by Kentucky Medicaid recipients. We interviewed personnel with responsibilities for the program at all the above-mentioned locations.

We also interviewed, at their offices located throughout the State, 31 physicians who participated in the Kentucky Medicaid program. We were accompanied by professional personnel of the Kentucky Department of Health who provided us with their determinations regarding apparently excess and unneeded medical care.

APPENDIXES

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
WASHINGTON, D.C. 20201

OFFICE OF THE SECRETARY

OCT 8 1970

Mr. John D. Heller
Assistant Director
Civil Division
U.S. General Accounting Office
Washington, D.C. 20548

Dear Mr. Heller:

The Secretary has asked that I reply to the draft report of the General Accounting Office on its review of "Opportunity for Improvement in the Utilization Review of Physician Services Provided Under the Medicaid Program in Kentucky."

Enclosed are the Department comments on the findings and recommendations in your report. The comments of the State of Kentucky are included as an attachment.

We appreciate the opportunity to review and comment on your draft report and welcomed your suggestion that the appropriate State official be afforded the same opportunity.

Sincerely yours,

James B. Cardwell
Assistant Secretary, Comptroller

Enclosures

COMMENTS ON GENERAL ACCOUNTING OFFICE DRAFT REPORT

OPPORTUNITY FOR IMPROVEMENT IN THE UTILIZATION REVIEW OF

PHYSICIAN SERVICES PROVIDED UNDER THE MEDICAID PROGRAM IN KENTUCKY

The draft report of the General Accounting Office presents a factual picture of the situation in Kentucky with regards for opportunities to improve the utilization review of physician services, and is consistent with the findings of the SRS Regional Office on these points.

Comments obtained by us from an official of the State of Kentucky generally agreed with the findings reported. The State pointed out that during the current calendar year there has been special emphasis placed on recipient profiles both from the standpoint of physician visits and drug utilization. A copy of the State's comments is attached.

The first recommendation [p. 23 of this report] provides that HEW establish guidelines for utilization reviews of physician services including provision for the establishment of medical services utilization parameters to enable the identification of potential program over-utilization.

Utilization review guidelines as noted in the report have been in draft form for quite some time. The guidelines have been held from final publication while under consideration by the McNerney Task Force on Medicaid and Related Programs. The final report on the Task Force, which was issued on June 29, 1970, stated that a strong, specific, and comprehensive Federal policy should be developed which would require the States to establish medical program effectiveness systems designed to control program utilization. We hope to issue utilization review guidelines in the near future.

In addition to these guidelines, we have executed contracts for the implementation of a pilot medical surveillance and utilization review program with four States; Colorado, Oklahoma, Rhode Island, and West Virginia. It is hoped that the results thus obtained will strengthen the ability of States to monitor, plan, and administer the title XIX program. Further, the model system developed through this pilot project will be made available for adoption by all participating States.

The second recommendation [p. 24 of this report] suggests that HEW take appropriate measures to provide for more effective monitoring of utilization review of physician services performed by the States.

We plan to shortly institute a closer monitoring and liaison program with each individual State agency by each of the SRS/MSA Regional Offices along with the cooperation of the Washington Central Office. Under this new program, we plan to have a closer relationship with the State agencies along with more frequent visits and detailed reviews of State operations. We will continue to evaluate the adequacy of these guidelines in light of information brought to our attention through our continuous monitoring of State programs and make any needed adjustments.

The third recommendation [p. 24 of this report] provides that HEW should revise the regulation (D-5810 of the Public Assistance Handbook Supplement D) to reduce the 24-month period permitted vendors for billing purposes. We are in the process of amending the regulations to reduce the 24-month limitation period to a 6-month period for all services. Reimbursement policy for retroactive adjustment of payments providing for reasonable costs for inpatient hospital services, skilled nursing home services, home health services, and clinic services will remain at the 24-month period due to obvious delays required in making final settlements.

COMMONWEALTH OF KENTUCKY
DEPARTMENT OF ECONOMIC SECURITY
FRANKFORT

LOUIE B. NUNN
GOVERNOR

MERRITT S. DEITZ, JR.
COMMISSIONER

September 8, 1970

Mrs. Virginia M. Smyth
Regional Commissioner, SRS
Department of Health, Education, & Welfare
Regional Office IV
50 Seventh Street, N. E.
Atlanta, Georgia 30323

Dear Mrs. Smyth:

The draft of the report relating to Physician Services provided under the Kentucky Medical Assistance Program prepared by representative of the Controller General of the United States has been received and reviewed.

In general, it is believed that the report undertakes to present an objective review of that segment of Kentucky's Medical Assistance Program dealing with provided Physician's services. It is felt, however, that the emphasis placed upon the program's deficiencies tend to overshadow Kentucky's effort to develop, for the most part utilizing its own talent, a plan for making available to a desperately needy segment of the Commonwealth's citizens a form of assistance which had too long been neglected. Moreover, it appears doubtful that full consideration could have been accorded many geographic as well as socio-economic problems that were encountered in the formulation of a plan of this magnitude. It is not the purpose of this reply to minimize the desirability of constant efforts to improve the program through the use of adequate controls. Rather the purpose of this reply is to point out that there has been a constant and continuing effort to develop a means of extending a needed service to the largest number of people needing the service at the same time that the means of accomplishing this task was being developed and controlled.

Relatively early in the program the problem of controlling over-utilization in the mountainous section of the Commonwealth became apparent. Strange though it may seem, family sizes, difficulty of transportation and scarcity of physicians contribute to the difficulty of control. Even so, effective steps to control abuses were initiated and the salutary effect of the measures undertaken is believed to be substantial. Efforts to improve control of over-utilization of physicians' services and other phases of the program, are continuing and personnel to be utilized in this effort are being added as rapidly as qualified persons can be attracted to the staff.

During the current calendar year, there has been special emphasis placed on recipient profiles both from the standpoint of physician visits and drug utilization. These profiles are being utilized to identify heavy users and field workers are assigned to examine, by personal contact, the causes of what may appear to be excessive use of the program services. The field workers' reports are reviewed by appropriate professional teams and recommended action is followed.

As reported, Kentucky's program adopted the 24 month plan for submission of providers' statements for services but to make possible a better use of recipient utilization print-outs, the period within which provider statements must be submitted has been reduced to 6 months and will become effective October 1, 1970. A shorter period was considered but because of difficulties which can develop as a result of eligibility delays, the 6 month period was considered more feasible.

The feed-back from the print-out of recipients' use of program services is being utilized as a basis for identifying cases requiring personal interviews and other appropriate action. Lock-in plans, within the framework of the approved provisions, are presently being considered in instances where over-utilization appears to be evidenced. Reference has been made in the report to States where successful controls are in operation but personal contact with persons responsible for the control function in at least one of the named States appears to indicate a system less effective from a control point of view than Kentucky's plan.

None of the comments contained herein is intended to be other than explanatory of what Kentucky is doing and is planning to do in its effort to be constantly alert to the need to search for means and methods to upgrade the program both as to service and control. Kentucky would be pleased to receive suggestions for improvements particularly such suggestions as may be provided by the guidelines manual referred to in the report.

Very truly yours,

MERRITT S. DEITZ, JR.

PRINCIPAL OFFICIALS OF THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE HAVING RESPONSIBILITY FOR THE ADMINISTRATION OF ACTIVITIES DISCUSSED IN THIS REPORT

	Tenure of office	
	From	To
SECRETARY OF HEALTH, EDUCATION, AND WELFARE:		
Elliot L. Richardson	June 1970	Present
Robert H. Finch	Jan. 1969	June 1970
Wilbur J. Cohen	Mar. 1968	Jan. 1969
John W. Gardner	Aug. 1965	Mar. 1968
ADMINISTRATOR, SOCIAL AND REHABILITATION SERVICE:		
John D. Twiname	Mar. 1970	Present
Mary E. Switzer	Aug. 1967	Mar. 1970
COMMISSIONER, MEDICAL SERVICES ADMINISTRATION:		
Howard N. Newman	Feb. 1970	Present
Thomas Laughlin, Jr. (acting)	Sept. 1969	Feb. 1970
Dr. Francis L. Land	Nov. 1966	Sept. 1969

U.S. GAO Wash., D.C.