REPORT TO THE
COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

Functioning Of The Missouri 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

MARCH 27, 1972

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

B-164031(3)

Dear Mr. Chairman:

This is the first of four reports on our reviews of the functioning of State systems for reviewing the use of medical services financed under Medicaid. 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 Missouri.

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,

Elmer B. Staats

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 MISSOURI SYSTEM FOR REVIEWING THE USE OF MEDICAL SERVICES FINANCED UNDER MEDICAID

Social and Rehabilitation Service 179
Department of Health, Education, 22
and Welfare B-164031(3)

D I G E S T

WHY THE REVIEW WAS MADE

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

The purposes of State reviews of medical services under medicaid are to safeguard against unnecessary medical care and services and to ensure that payments financed by Medicaid are reasonable and 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."

This report covers the utilization review system followed in Missouri. Other reports will cover the systems followed in Florida, Maryland, and Massachusetts.

Medicaid is a grant-in-aid program administered for the Federal Government by the Department of Health, Education, and Welfare (HEW). Under the program the Federal Government pays part of the costs incurred by States in providing medical care to persons unable to pay.

Congressional concern over rapidly rising Medicaid costs led to the enactment of the Social Security Amendments of 1967 which included a requirement that each State Medicaid plan include a utilization review system.

The Chairman suggested that GAO inquire into such matters as the

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

--achievement of results under the utilization review systems,

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

--extent of assistance given by HEW to the States in the development of the systems.

To obtain information on the first two of these matters, GAO evaluated (1) general utilization review controls applicable to all medical services,

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(2) general controls applicable to recipients, (3) specific controls applicable to institutional medical services, and (4) specific controls applicable to noninstitutional medical services.

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

FINDINGS AND CONCLUSIONS

Missouri has developed a utilization review system which includes manual and computer controls. These controls are designed to assist in identifying and evaluating services exceeding established standards and in correcting utilization determined to be improper. (See p. 14.)

Missouri's utilization review system does not provide for the systematic accumulation of data showing the amounts of reductions in Medicaid costs or other benefits resulting from utilization review or of data comparing the costs of utilization review with the benefits that it provides.

Missouri's system, however, is producing positive benefits. Payments to hospitals were reduced by about $260,000 over a 1-year period. Payments to physicians were reduced by about $715,000 over a 1-year period. (See p. 42.)

During fiscal year 1971 Missouri paid about $60 million for medical benefits furnished to 273,000 welfare recipients. Of the $60 million, about $54 million was paid to 8,821 providers of medical services and about $6 million was paid to the Social Security Administration for Medicare insurance premiums. About $55 million was subject to Federal participation at 59.29 percent.

Controls applicable to all Medicaid services

Missouri has established procedures to ensure that

- --recipients and providers are eligible to participate in the program,
- --services paid for are covered by the program,
- --amounts paid are reasonable, and
- --claims have not been paid previously.

GAO believes that these controls are adequate. (See p. 16.)

Controls applicable to Medicaid patients

Usage standards which identified patients receiving too much care under the program were established. Such patients were restricted to one physician and one pharmacist, except for emergencies. This procedure is effective.

For example, one patient's medical history showed that, during the 3 months prior to his restriction. he visited four physicians a total of 30 times

and had five pharmacists fill a total of 16 prescriptions. During the 3 months after his restriction, he made a total of eight visits to two phyicians and had four prescriptions filled by one pharmacist. (See p. 17.)

Controls applicable to Medicaid institutional services

Missouri's utilization review system generally is effective in controlling the use of Medicaid institutional services. (See p. 25.)

Of the $60 million paid by Missouri for Medicaid services in fiscal year 1971, about $32 million, or 53 percent, was for institutional services. The State established controls over skilled nursing-home services to ensure that rates paid are reasonable and that persons in nursing homes require skilled nursing care.

During the 9-month period ended September 1971, the State determined that 662 of 5,529 applicants did not require skilled nursing-home care. (See p. 19.)

The State established controls over hospital care to ensure that

--rates are reasonable,
--recovery is made of amounts due from other sources, and
--care provided is medically necessary. (See p. 20.)

The system is designed to identify providers and patients who exceed established limits of Medicaid service.

The State has limited payment for hospital care to a maximum of 14 days for each admission. Generally the need for continued hospital care is not evaluated until after recipients have been in the hospital for 14 days. (See p. 23.)

The need for continued hospital care should be evaluated earlier than 14 days after admission. (See p. 42.)

During a 1-year period, medical audits of hospitals which have relatively high daily costs and/or long average lengths of stay have resulted in the disapproval for payment of 2,425 hospital-days valued at $134,000.

Benefits obtained from these medical audits warrant their expansion to a greater number of hospitals. (See p. 22.)

Controls applicable to Medicaid noninstitutional services

Missouri has an effective utilization review system for Medicaid services provided outside of institutions. Many useful controls have been implemented. Periodic evaluations should be made of each control or group of controls, however, so that the more effective controls can be expanded and the less effective controls altered, discontinued, or replaced. State

officials agreed with GAO's suggestion that such evaluations be made. (See p. 38.)

Most of the Missouri Medicaid payments for medical services received outside of institutions are for physician services and prescription drugs. (See p. 13.)

The State has established a number of specific controls aimed at controlling the use of physician services and prescription drugs. For example, special analyses are made of the services provided by every physician whose claims for a month exceeded $500. A random test of claims for eight such physicians showed that the amounts of the claims had been reduced an average of 43.5 percent. (See p. 27.)

As another example, a State pharmacist travels throughout the State to visit pharmacies and physicians providing drugs to Medicaid patients. He reviews prescription files to verify claims, checks questionable claims referred to him by other staff members, and visits selected welfare recipients to verify that they received the kind and quantity of drugs indicated on the billings.

Five pharmacists have been removed from Missouri's Medicaid program because analyses of their claims indicated overuse and failure to cooperate in correcting the problem. (See p. 33.)

Adequacy of State resources

Missouri's utilization review system is operated by 85 full-time employees and six part-time employees. State officials expressed the view that State resources were adequate to perform effective reviews, and GAO's examination indicated that such was the case. (See p. 39.)

Extent of assistance by HEW

The Missouri Medicaid program began in October 1967. 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. Regional employees of HEW were not given the guidelines or training necessary to adequately assist the State in developing its utilization review system. (See p. 40.)

In September 1971 HEW provided Missouri with a model system providing a broad framework within which the State could develop detailed system specifications to meet requirements particular to its own system. The Missouri system contains most of the key elements of the model system, and State officials felt that some of the detailed data generated under the model system would be superfluous. (See p. 41.)

RECOMMENDATIONS OR SUGGESTIONS

HEW should assist the State and should monitor State actions to

--periodically evaluate the effectiveness of utilization review controls,

--expand the utilization review of hospital care,

--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. 43.)

CHAPTER 1

INTRODUCTION

In response to a request dated July 2, 1971 (see app. I), from the Chairman, House Committee on Ways and Means, the General Accounting Office has reviewed the functioning of the utilization review system under the Medicaid program in Missouri. 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,

--achievement of results under the utilization review systems,

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

--extent of assistance given by HEW to the States in the development of the systems.

To obtain information on the first two of these matters, we evaluated (1) general utilization review controls applicable to all medical services, (2) general controls applicable to recipients, (3) specific controls applicable to institutional medical services, and (4) specific controls applicable to noninstitutional medical services.

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

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 the 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 Missouri's Medicaid costs in fiscal year 1971 was 59.29 percent. Medicaid, like other public assistance programs, is a Federal-State program operated under State direction within Federal guidelines. Within such guidelines each State decides who will be included in the program, what services they will be entitled to receive, and how the program will be administered.

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. For fiscal year 1971 the States and jurisdictions having Medicaid programs spent about $5.9 billion, of which about $3.2 billion was the Federal share.

ADMINISTRATION OF MEDICAID PROGRAM

Medicaid is administered at the Federal level by the Social and Rehabilitation Service, HEW. State plans--which provide the basis for Federal grants to the States for their Medicaid programs--are approved by the 10 Regional Commissioners of the Service.

Under the act States have the primary responsibility to initiate and administer their Medicaid programs. The HEW Regional Commissioners determine whether approved State programs adhere to the provisions of the 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 Kansas City, Missouri, provided general administrative direction for the Medicaid program in Missouri.

The HEW Audit Agency is responsible for auditing the manner in which Federal and State responsibilities for the Medicaid program are being discharged. The HEW Audit Agency has made--and is currently making--a number of reviews of State Medicaid programs. In a July 1969 report on Missouri's Medicaid program, the HEW Audit Agency pointed out that the scope of the State's utilization reviews needed to be more comprehensive and that more emphasis should be placed on the development and evaluation of recipients' medical histories.

PERSONS ELIGIBLE FOR MEDICAID

Persons receiving public assistance payments under other titles[1] of the Social Security Act are entitled to Medicaid benefits. Almost all other persons covered by Medicaid are persons whose incomes or other financial resources exceed standards set by the States to qualify for public assistance payments but whose resources are not adequate to pay all the costs of their medical care. Coverage of this latter group is at the option of the 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 March 1971, 27 States or jurisdictions had Medicaid programs covering both the categorically needy and the medically needy and 25 States or jurisdictions, including Missouri, had programs covering only the categorically needy.

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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.

REQUIREMENTS FOR UTILIZATION REVIEW

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

Congressional concern over rapidly rising Medicaid costs led to the enactment of the Social Security Amendments of 1967. One of these amendments added a requirement 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 requirement, the 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 which monitors 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 the States considerable latitude in their approach to utilization review.

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

In April 1969 the Service sent draft guidelines for utilization reviews to its regions for comment. The

guidelines 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 see that services rendered are based on actual need and that frequency of care and service is appropriate to that need. The draft guidelines stated also that utilization reviews should include (1) methods of reviewing the need for medical services before the services are 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 to States 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.

CHAPTER 2

MISSOURI MEDICAID UTILIZATION REVIEW SYSTEM

The Division of Welfare--a part of the Department of Public Health and Welfare--is the single State agency responsible for administering the Missouri Medicaid program which began in October 1967. The division has offices in 15 administrative districts, in each of the 114 counties of the State, and in the city of St. Louis.

Missouri provides Medicaid services for all categorically needy persons. (See p. 9.) In addition to providing the services required by title XIX of the Social Security Act, as amended, the Missouri Medicaid program provides

--dental services,

--prescription drugs,

--emergency ambulance services,

--mental and tuberculosis hospital services, and

--payment of Medicare insurance premiums for recipients of cash assistance.

The Division of Welfare has the authority to establish the extent to which these services will be furnished and the methods and amounts of reimbursement that will be made to medical providers.

The Bureau of Medical Services of the Division of Welfare has the primary responsibility for administration of the utilization review system. The bureau obtains assistance from its professional medical staff in developing criteria to identify potential program abuses. Also the Division of Health and the Division of Mental Diseases have agreed to accept certain responsibilities relative to utilization reviews in institutions.

During fiscal year 1971 Missouri paid about $60 million for medical benefits furnished to 273,000 welfare recipients. The $60 million included about $54 million paid to 8,821 providers of medical services and about $6 million paid to the Social Security Administration for Medicare insurance premiums. About $55 million was subject to Federal participation at 59.29 percent.

Medicaid services	Fiscal year 1971 Recipients	Providers	Payments (000 omitted)
Institutional:			
Skilled nursing homes	7,300	144	$14,755
Inpatient hospitals	53,300	560	14,579
Mental and tuberculosis institutions	1,000	9	2,242
Noninstitutional:			
Physicians	193,500	5,156	9,654
Prescription drugs	191,500	1,217	9,363
Outpatient hospitals	79,300	299	1,849
Dental care	37,000	1,227	1,469
Emergency ambulances	(a)	169	30
X-ray and laboratory services	(a)	40	20
Total	(b)	8,821	$53,961
Medicare insurance premiums		-	6,068
Total		8,821	$60,029

[a]Data was not readily available.

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

During fiscal year 1971 about 29,500 more recipients received medical services than in fiscal year 1970, although the State Medicaid appropriation was reduced by $340,000. This was accomplished by reducing allowable charges and by curtailing or eliminating certain services.

The Bureau of Medical Services has developed a utilization review system which includes controls to identify recipients and providers whose use of the program has exceeded established standards. Once identified, their use of the program is evaluated and, if necessary, is restrained. Missouri has had utilization controls since its Medicaid program was initiated in 1967. Significant additions, including controls over recipient use of the program, were made in 1970 and 1971.

Missouri's utilization review system does not provide for the systematic accumulation of data (1) showing the amounts of reductions in Medicaid costs or other benefits resulting from utilization review or (2) comparing the costs of utilization review with the benefits it provides.

Specific controls applicable to institutional services and noninstitutional services are discussed in chapters 3 and 4, respectively. The general controls applicable to all services and those relating to the use of the program by recipients are discussed in the following sections.

GENERAL CONTROLS APPLICABLE TO ALL SERVICES

The Bureau of Medical Services has established procedures to ensure that (1) recipients and providers are eligible to participate in the program, (2) services paid for are covered by the program, (3) amounts paid are reasonable, and (4) claims have not been paid previously.

Controls relating to eligibility

Each month the Division of Welfare mails identification cards to the recipients. When obtaining services the recipients show these cards to the providers who must identify the recipients by names and numbers when they bill the Division of Welfare. The identification data from the bills is compared with the master eligibility file by the computer system, to ensure that only services provided to eligible recipients are paid.

Each quarter the computer system prepares a listing of deceased recipients showing the dates of deaths. The Bureau of Medical Services disallows claims for services after the dates of recipients' deaths.

The Division of Welfare requires each provider to sign an agreement in order to participate in the program. The agreement requires that the provider abide by the policies and procedures of the division and accept as payment in full the amount determined by the division to be reasonable. The division has established computer controls to ensure that payments are made only to eligible providers.

Controls relating to covered services

Missouri has limited the extent to which Medicaid services will be provided. For example, Missouri has limited its drug program to specific prescription drugs and its dental program to a specific number of dental procedures.

Each medical service authorized by the Missouri Medicaid program has been assigned a code number. This code number and the allowable cost for the service has been entered in the computer system. Employees of the Division of Welfare review each bill and assign appropriate code numbers to authorized services shown on the bill. If the service billed is not authorized by the program, the employee does not assign a code number and the bill cannot be processed for payment.

Controls relating to reasonable charges

Missouri has authorized the Division of Welfare to define reasonable costs and to establish the allowable charges for its Medicaid program. The division has established the amount it will allow for each medical service covered by the program. Payments for institutional care are based on reasonable costs or rates negotiated by the Division of Welfare. These amounts are included in the computer system. As bills are processed through the computer system, the charges on the bills are compared with the allowable charges and the lesser of these amounts are paid.

Controls to correct duplicate payment

During fiscal year 1971 the Division of Welfare processed about 2.9 million claims submitted by about 8,800 providers. The computer system periodically compares claims

processed and prints a listing of apparent duplicate bills. This program has been in effect since December 1967.

A second program, initiated in June 1968, compares medical service codes and dates of service and prints a listing of individual services that appear to have been included on previous claims. This program, which initially covered payments made during a 3-month period, was expanded in July 1971 to include payments made for a 12-month period. Division of Welfare employees analyze this listing and obtain the necessary information to resolve apparent duplicate payments.

Evaluation of general controls

We believe that the controls developed to ensure that only eligible recipients and providers participate in the program are adequate. We believe also that the controls over payments generally are adequate to ensure that duplicate claims are detected and that only the allowable charges for covered services are paid.

CONTROLS RELATING TO THE USE OF THE PROGRAM BY RECIPIENTS

Prior to 1970 the Division of Welfare did not have an effective method of identifying recipients who made excessive use of the program. As pointed out in an HEW audit report covering calendar year 1968, the utilization review system in Missouri was directed toward medical providers. Medical histories were not collected on a single record to aid in identifying recipients who were abusing the program. In May 1969 the Division of Welfare began placing the medical history of each recipient on microfilm. This provided a permanent medical history that could be reviewed to identify overutilization of the program.

In February 1970 the Bureau of Medical Services began controlling recipients who, on the basis of comments received from their physicians, were overutilizing the program.

In August 1970 the Bureau of Medical Services established frequency limits (parameters) for evaluating the

reasonableness of services obtained by recipients. When a recipient obtained services from two or more physicians, the bureau evaluated the recipient's need for the services. Because of the large volume of cases requiring review under this parameter, the use of the parameter was discontinued.

In June 1971 parameters were adopted which provided for the identification of recipients who obtained medical services from four or more physicians, pharmacists, hospitals, and/or dentists in a 3-month period. These parameters provided also for the identification of recipients who received 50 or more services in a 3-month period.

If further analysis indicates that a recipient is overutilizing the program, he may be counseled regarding the use of the program and he may be restricted, except for emergency or other justifiable reasons, to one physician and one pharmacist of his choice. The recipient's physician is advised of the extent of services being provided to the recipient and is requested to assist the Division of Welfare in ensuring that only necessary services are provided.

In June 1971 the bureau restricted 77 recipients to one physician and one pharmacist. By December 1971 the number of restricted recipients had increased to 311. Our review of the use of the Medicaid program by 15 recipients showed that, after these recipients had been restricted, physician visits were reduced 72 percent and drug prescriptions were reduced 65 percent. For example, we compared one recipient's use of the program for two 3-month periods. His medical history showed that, during the 3 months prior to his restriction, he visited four physicians 30 times and had five pharmacists fill 16 prescriptions. During the 3 months after his restriction, he made eight visits to two physicians and had four prescriptions filled by one pharmacist.

Evaluation of controls over recipient use

The controls implemented in June 1971 appear to be adequate to identify recipients whose use of the program exceeds the frequency limits set by the State. Actions by the Division of Welfare to enlist the assistance of the

recipients' physicians, to counsel the recipients about their use of the program, and to restrict their use of the program, as noted above, appear to effectively control the recipients' use of the program.

CHAPTER 3

UTILIZATION REVIEW OF INSTITUTIONAL SERVICES

Of the $60 million paid by Missouri for Medicaid services in fiscal year 1971, about $32 million, or 53 percent, was for institutional services. (See p. 13.) In addition to developing the general controls discussed in chapter 2, the Bureau of Medical Services has developed specific controls over institutional services.

CONTROLS OVER SKILLED NURSING HOMES

The State of Missouri paid about $15 million for skilled nursing-home care provided to about 7,300 recipients during fiscal year 1971. Missouri provides for nursing-home care in skilled nursing homes and in extended-care facilities.

The Division of Welfare established controls over skilled nursing-home services to ensure that rates paid are reasonable and that persons in the facilities require skilled nursing care.

Nursing-home rates

The Division of Welfare sets the rate that will be paid to each nursing home by taking into account such factors as Medicare extended-care-facility rates and the rates for other skilled nursing homes in the area. The daily rates for Medicaid patients ranged from $5 to $16. In fiscal year 1971, due to a reduction in State funds, the Division of Welfare reduced nursing-home rates 5 percent. A recipient whose income exceeds his personal needs is required to apply the excess income toward the cost of skilled nursing care. The computer is programmed to determine the amount to be paid for each nursing-home claim by considering the daily rate at the home and the amount the recipient is to pay.

Need for skilled nursing care

The determination of need for skilled nursing care is initiated when a county welfare caseworker requests a

physician's evaluation regarding the need for such care. The physician's evaluation and the caseworker's recommendation are forwarded to the Bureau of Medical Services for approval by the bureau's medical consultants. At this time the consultant specifies a date for reevaluation of the recipient's need for continued skilled nursing-home care. The reevaluation is based on the physician's examination and the caseworker's recommendation.

During the 9-month period ended September 1971, the Bureau of Medical Services reviewed 5,529 requests for skilled nursing-home care. The bureau approved 2,681 initial applications and 2,186 requests for continued care. The bureau also determined that 662 of the applicants did not require skilled nursing-home care.

County welfare caseworkers make periodic visits to the nursing homes to ensure that the recipients remain eligible for public assistance and that they are receiving care in the homes. The Division of Welfare also compares hospital billings with claims submitted by skilled nursing homes to ensure that the nursing homes are not billing for any days during which the recipients were in hospitals.

CONTROLS OVER INPATIENT HOSPITALS

The State of Missouri paid about $15 million for inpatient hospital services provided to about 53,000 recipients during fiscal year 1971. Since July 1970 the Division of Welfare has limited payment for hospital care to a maximum of 14 days for each admission, which has resulted in 43,174 days of care that were not paid for by the program.

The Division of Welfare has established controls over hospital care designed to ensure that the (1) rates paid are reasonable, (2) amounts due from other sources are recovered, and (3) care provided is medically necessary.

Reasonableness of hospital rates

Hospitals are reimbursed on the basis of Medicare interim rates until final settlements are made on the basis of reasonable costs of the services provided. Medicare fiscal intermediaries are responsible for determining the

reasonable costs of hospital care on the basis of periodic audits of the hospitals. Division of Welfare officials said that final settlements had not been made with hospitals because access to the audits made by the Medicare fiscal intermediaries had not been granted.

Recovery of payments from other source

Medicaid legislation requires that payments from other sources, such as Blue Cross and commercial insurance, be used in lieu of public funds. The county welfare office provides insurance data to the Division of Welfare for inclusion on a computer tape of insurance resources. Inpatient hospital claims and physicians' services claims are processed against the resource tape to determine what resources are available. Inquiries are made of the provider and the insurance company if no refund is received within a month. When the insurance payment is made to the recipient, the recipient is requested to apply the payment to his hospital bill. When the insurance payment is made to the hospital, the division prepares a credit adjustment and notifies the hospital.

Medical necessity for care

Inpatient hospital care has been subject to various utilization review practices since the Missouri Medicaid program began. Hospital claims are reviewed to delete luxury items or other noncovered charges and to determine whether the amounts claimed are correct. These reviews have resulted in reductions of about $129,000 for the year ended August 31, 1971. For claims exceeding $1,000 and for which the diagnoses do not appear to justify the lengths of stay, charts and supporting records are obtained and reviewed by Division of Welfare physicians.

Prior to May 1970 the division maintained manual records which indicated the average lengths of hospital stay. This operation was programmed into the computer in May 1970 and was refined further in July 1971.

The computer section periodically reports hospital data showing the average lengths of stay for recipients and the average amounts paid for each hospital day. The Bureau of Medical Services uses this list to identify hospitals which

have relatively long average lengths of stay and hospitals which have high daily costs. Hospitals so identified may be subjected to detailed analysis of their claims. From June 1970 the bureau maintained a listing of hospitals whose claims were being audited. Generally about 25 hospitals are on this list at one time. Physician consultants of the Bureau of Medical Services audit claims from these hospitals to determine whether admissions and the lengths of stay were necessary. Payments are approved only for the number of days justified by hospital data supporting these claims. The bureau continues to audit claims from these hospitals until it is satisfied that Medicaid utilization is acceptable. As a result of such audits, 2,425 hospital days valued at $134,000 were disapproved for payment. The average daily rate for the hospital-days that were disallowed by the medical audits was about $55.

Following are examples of days disallowed by review of medical claims from selected hospitals during the period September 1970 through August 1971.

Hospital	Number of claims	Days claimed	Days disallowed by medical audit
A	257	1,465	317
B	61	536	37
C	12	186	20
D	654	4,420	547

Information obtained from the Division of Welfare indicated that the average length of stay for inpatient hospital care was reduced from 8.94 days in the first half of calendar year 1969 to 6.38 days in the first half of calendar year 1971.

Only hospitals certified for the Medicare program are permitted to participate in the Missouri Medicaid program. The State Division of Health is responsible for certifying hospitals and for determining whether hospitals have acceptable utilization review plans. About once every 2 years, the Division of Health reevaluates hospitals' utilization review plans to ensure compliance with program requirements.

Medicare requires each hospital, as a part of its utilization review plan, to (1) review, on a sample or other basis, admissions, durations of stays, and professional services furnished and (2) review each case of extended duration. The review of extended-duration cases is of little benefit to the Medicaid program because hospitals in Missouri generally have defined an extended-duration case as one exceeding 14 days of hospital care and because the State will not pay for more than 14 days of care. (See p. 20.) Evidence that utilization reviews at many hospitals could be improved is indicated by the 2,425 hospital-days disallowed by the Bureau of Medical Services audit.

Division of Welfare officials agreed that the application of utilization review techniques to hospital stays of less than 14 days would be beneficial. They said that they planned to (1) suggest that participating hospitals review Medicaid cases 8 days after admission to evaluate the need for continued care and (2) increase the number of hospitals covered by Bureau of Medical Services audits. We believe that these changes will improve the utilization review of inpatient hospital services.

CONTROLS OVER MENTAL AND TUBERCULOSIS INSTITUTIONAL SERVICES

Eight State institutions provide care for mental diseases, and one State institution provides care for tuberculosis. During fiscal year 1971 the Division of Welfare paid about $2.2 million to these institutions for medical services provided to about 1,000 recipients.

Payment to an institution is made quarterly on the basis of the established daily rate for that institution and of the total number of days of care given to eligible recipients. Title XIX allows payments to mental and tuberculosis hospitals for services provided to persons 65 years of age or older.

The Division of Welfare has agreed to reimburse the Division of Mental Diseases for the reasonable costs of medical care provided to recipients in mental institutions. The Division of Mental Diseases (1) is responsible for recipients' care and treatment, (2) is responsible for the identification of recipients who no longer require hospital care, and (3) participates with the Division of Welfare in making alternate plans for care. The Division of Welfare provides staff to process and determine eligibility and to periodically participate in joint consultation with the State hospital staff to review the recipients' conditions, progress, and needs.

Division of Welfare officials told us that the general controls and utilization review procedures used for inpatient hospital care were applied to the State tuberculosis institution. During fiscal year 1971 the tuberculosis institution was paid about $74,000 for care provided to Missouri Medicaid recipients.

EVALUATION OF CONTROLS OVER INSTITUTIONAL SERVICES

The review of extended-duration cases by hospital utilization review committees appears to be of little benefit to the Missouri Medicaid program. (See pp. 22 and 23.) Division of Welfare officials said that they planned to encourage hospitals to review Medicaid cases 8 days after

patients' admission to evaluate the need for continued care. They said also that they planned to increase the number of hospitals covered by medical audits. We believe that these changes will help to prevent overutilization of hospital services by Medicaid recipients.

The Division of Welfare has a utilization review system which identifies providers and recipients who exceed established limits of service and which provides for the review of services to determine whether the care was necessary. If the division determines that overutilization exists, appropriate corrective action is taken. We believe that the system generally is effective in controlling the use of institutional services.

CHAPTER 4

UTILIZATION REVIEW OF NONINSTITUTIONAL SERVICES

The Division of Welfare, aided by its computer, records and reports statistical data regarding the services provided by medical groups and individual practitioners. This data enables the Bureau of Medical Services to evaluate the use of the program by providers who have exceeded parameters set by the bureau. The controls applicable to noninstitutional services are discussed in detail in the following sections.

CONTROLS OVER PHYSICIANS' SERVICES

About 194,000 recipients obtained services from 5,156 physicians under Missouri's Medicaid program during fiscal year 1971. These services cost about $9.7 million.

To provide for physician services for eligible recipients aged 65 or older, the State has purchased Medicare part B insurance. The claims-processing system--using computer controls--determines whether the amounts billed for recipients under 65 years of age are within the amounts allowed under the State's program. For these recipients the physicians are paid the lesser of (1) the amounts shown on their claims or (2) the maximum amounts allowed under a State-established schedule of fees. The Division of Welfare, by applying the fee-schedule maximums, reduced physicians' claims about $715,000 during calendar year 1970.

The above procedures are supplemented by additional utilization review controls. Most of these controls are feasible because of the ability of the computer to store, analyze, and report information relating to all claims submitted by a particular physician or for services to a particular patient. Three of the controls are discussed in the following sections.

Payments in excess of $500 a month

In June 1968 the computer section began producing a monthly report listing, in summary form, information on every physician whose payment for a month exceeded $500.

For each physician so identified, the report shows (1) the total number of services provided, visits made, recipients seen, and amounts paid and (2) the average amount paid for each service, visit, and recipient.

The Medical Claims Payment Supervisor, assisted by the Bureau of Medical Services' physician consultants, examines this report to determine the reasonableness of the services provided. If overutilization appears to exist, the supervisor may obtain from the computer section a detailed report on any of the physician's past billings.

After reviewing this report, if overutilization still appears to exist, the consultants may contact the physician and/or the recipients to discuss the claims. When a decision is made by the consultants that any of the physician's claims are improper, an adjustment is made. If a trend of overutilization is noted, the physician's name is placed on a "problem doctor" list and his future claims are subjected to special review. A physician's name also may be added to the problem-doctor list when overutilization has not been determined but is suspected. As of June 1971 the Bureau of Medical Services had about 200 physicians' names on the problem-doctor list.

In a limited test we examined the effectiveness of the special analysis made of claims submitted by physicians on the problem-doctor list. We randomly selected 58 claims of recipients under 65 years of age submitted in September 1971 by eight such physicians and found that the claims, as submitted, had been reduced an average of 43.5 percent. Most reductions were due to the physicians' charging fees in excess of those allowed by the State, but about 5.1 percent were reductions for services not considered medically necessary.

Following are examples of comments from a June 1971 report prepared by the bureau relating to claims submitted by physicians who were then on the problem-doctor list.

Physician	Comments
A	"All 38 claims had to be adjusted. He overutilizes on X-rays and several were not allowed."
B	"Several of his 59 claims had to be adjusted. He overutilizes on X-rays, injections, cultures, etc. Several were not allowed."
C	"He had 22 claims with no problems."
D	"He had 7 claims with no problems. He has changed."
E	"He had 108 claims. He continues to overutilize on X-rays and urinalysis. Some were not allowed."
F (Neighborhood Health Center involving seven physicians)	"They sent in 195 claims this month. Their charges are outrageous. All claims were adjusted."
G (Private clinic involving 30 physicians)	"They had 268 claims this month. They continue to overutilize on laboratory, EKGs and X-rays. Several were not allowed."
H	"He had 200 claims. He overutilizes on everything. ***"

The Division of Welfare did not maintain statistics on the amounts of reductions made to claims submitted by physicians on the problem-doctor list; however, division officials believed that the reductions had been substantial and that the procedures were worthwhile.

The division also has established special procedures to be followed whenever the monthly report shows a physician whose claims exceed $3,000. Prior to releasing checks to any physician whose claims exceed $3,000 in any 1 month, the

Bureau of Medical Services makes a special analysis of the claims and reports its findings to the director of the Division of Welfare. Only after this analysis is made and after payment is considered proper is the check mailed to the physician. As of October 1971 the Division of Welfare withheld payments totaling about $4,200 from one physician's claims and was examining the propriety of all his past claims.

The following examples from a monthly report to the director illustrate the types of analyses which are made.

1. "Dr. *** saw 390 individual recipients on 555 dates of care. His average amount per recipient was $11.40. During 1970 Dr. *** saw 2,193 individual recipients on 8,306 dates of care, for a total of $66,698.33, or an average per recipient of $30.41. Services this month are primarily January and February 1971, and the remittance is very typical. There is no indication of overutilization, as such, just a lot of patients." Payments for the month totaled about $4,400.

2. "Dr. *** saw 288 individual recipients on 595 dates of care. His average amount per recipient was $13.41. During 1970 Dr. *** saw 808 individual recipients on 5,214 dates of care, for a total remittance of $40,230.79, for an average per recipient of $49.79. Dr. *** remittance is almost entirely [for] January 1971. He shows a definite tendency to see the same patient and the same family on a regular basis. ***" Payments for the month totaled about $3,900.

3. "Dr. *** saw 290 individual recipients on 407 dates of care, for an average amount per recipient of $12.52. During 1970 he saw 1,060 individual recipients on 4,884 dates of care, for a total remittance of $37,935.38, for an average amount per recipient of $35.78. Dr. *** is in a very good area of St. Louis to be participating as a Medicaid physician. He does show a good deal of in-hospital medical work this month, along with his regular office calls with laboratory services. On the 209 individual recipients seen by Dr. *** he performed 649

separate services. Dr. *** will be a regular on our list because of the area in which he practices. His services (billings) this month are primarily January and February 1971." Payments for the month totaled about $3,600.

Division of Welfare officials advised us that six physicians had had their participating agreements canceled because of overutilization and because of their failure to cooperate with the division in its attempt to correct the causes of such overutilization.

Payments in excess of $25,000 a year

During 1971 the division began auditing the records of any physician whose payments in the preceding year were $25,000 or more. During 1970 there were 27 such physicians, of whom 10 were specialists. The range of payments is shown below.

Amount paid	Number of doctors
$25,000 to $29,999	12
30,000 to 34,999	7
35,000 to 39,999	4
40,000 to 44,999	2
45,000 to 49,999	-
50,000 to 54,999	1
55,000 to 59,999	-
60,000 to 64,999	-
65,000 to 69,999	1
	27

As of September 1971 special audits of 18 of the physicians were completed. The audits were based on samples of recent billings submitted by the physicians and were aimed at determining whether the physicians' records supported the services claimed on the billings. In addition, interviews were held with the recipients to ascertain whether the services actually were received and to solicit opinions as to the quality of the care received. We were advised in December 1971 that eight additional audits had been completed.

Division officials advised us that no discrepancies had been found in the 26 completed audits. They also said that it was too early to judge whether the special audits were sufficiently useful to be continued in future periods.

Referrals to peer groups for review

The division's program for controlling payments for physician services includes arrangements for referring claims of a questionable nature to the Health Care Foundation of the Missouri State Medical Association and Missouri State Osteopathic Association. Decisions by the Division of Welfare concerning overcharges or overutilization would give recognition to the opinions expressed by these peer groups.

According to the Chief, Bureau of Medical Services, very few claims were referred to these groups because the results did not justify frequent submissions. We were advised that the professional consultants employed by the Bureau of Medical Services usually could resolve questions regarding overcharges or overutilization without resorting to peer groups. The Chief, Bureau of Medical Services, also stated that there was a $25 fee for every claim referred to these groups.

CONTROLS OVER PRESCRIPTION DRUGS

About 192,000 recipients obtained prescription drugs from 1,217 pharmacists during fiscal year 1971. These drugs cost about $9.4 million. The Division of Welfare, prior to paying these 1.7 million drug claims, determined that the recipients and providers were eligible to participate in the program.

Welfare recipients in Missouri may obtain about 153 basic drugs in about 432 varying potencies and forms. The Division of Welfare has sent to each participating pharmacist and physician a formulary (list of prescription drugs) identifying approved drugs and the allowable cost. The cost and a code number for each drug potency has been entered into the computer system; this ensures that payment is made only for the cost of the drugs in the formulary. The cost is determined by registered pharmacists employed by the Division of Welfare and is based on the cost to the retailer. In addition to the cost of drugs, a professional fee of $1 and a container fee of 10 cents are allowed. Hospitals and other institutions providing drugs to outpatients are not allowed the professional or container fees.

The division controls the utilization of the program by pharmacists and dispensing physicians by (1) limiting the amount of drugs that may be issued on any one prescription and the number of times that a prescription may be refilled, (2) having problem claims and providers reviewed by three registered pharmacists, and (3) limiting selected recipients in their use of the program.

Limits on drug quantities

A 30-day standard quantity for each drug item was established by the Division of Welfare. This information is used by the claims-processing system to identify claims that exceed this quantity. Division pharmacists determine if the quantity of drugs issued has been authorized by the prescribing physician. If the physician has not authorized the quantity claim, the pharmacist is notified and the cost for the additional quantity of drugs is not allowed. If the quantity prescribed exceeds a 30-day supply and is not a maintenance-type drug, one of the physician consultants will

contact the prescribing physician to determine if the quantity prescibed is justified. Physicians are requested to prescribe a 90-day supply of maintenance-type drugs when, in their opinion, it would not be harmful to the patient.

The Division of Welfare also limits the drugs obtained by a recipient to the original prescription and six refills within a 6-month period. If the pharmacist exceeds these limits, a letter is issued advising him that he is not complying with State requirements.

Reviews by registered pharmacists

Registered pharmacists employed by the State review all drug claims rejected by the computer and claims referred to them by the claims processors to determine whether payment should be allowed or whether additional supporting data should be obtained from the billing pharmacists.

One pharmacist travels throughout the State to visit pharmacies and dispensing physicians who participate in the program. This pharmacist reviews prescription files to verify drug claims, checks questionable claims referred to him by other staff members, and visits selected welfare recipients to verify that they have received the quantity and kind of drugs indicated on the billings. Five pharmacists were removed from the drug program because analyses of their claims indicated overutilization and because they failed to cooperate in correcting the problem.

Our review of a 5-week period in calendar year 1971 revealed that 67 percent of the traveling pharmacist's visits had been made to check duplicate claims and the frequency of prescription refills obtained by recipients.

Controls over drug usage by recipients

Each month since November 1970 the computer section has prepared a list of recipients who have received refills for the same prescription item two or more times in a 30-day period.

Recipients identified on this list may be counseled regarding their use of the program, and their physicians may

be requested to assist the State in controlling the recipients' use of the program. If necessary, the recipient may be restricted to one pharmacist and one physician.

CONTROLS OVER OUTPATIENT HOSPITAL SERVICES

The Division of Welfare paid $1.8 million for outpatient hospital services furnished to about 79,000 recipients during fiscal year 1971. The division processed about 209,000 claims for outpatient services. Claims for outpatient hospital services, in addition to being reviewed for eligibility of providers and recipients, are subject to the following controls.

Hospitals may charge a maximum of $5 for each outpatient visit. Additional services, such as X-ray and laboratory services, provided by the hospitals also may be billed when such services are provided on an emergency basis. Claims must show the justification for providing services.

Bureau of Medical Services employees review claims for outpatient care and assign procedure codes for each allowable service. The reasonable charge, as determined by the Division of Welfare, is programmed into the computer system, and, as claims are processed, the computer allows the lesser of (1) the amount billed by the hospital or (2) the reasonable charge.

In September 1971 the Bureau of Medical Services began identifying hospitals that were paid over $500 for outpatient services in a 30-day period. A supervisor in the bureau advised us that claims submitted by these hospitals would be reviewed to determine if overutilization existed.

CONTROLS OVER DENTAL SERVICES

The Missouri Medicaid program provided dental services to about 37,000 recipients in fiscal year 1971. These services were provided by 1,227 dentists and cost about $1.5 million.

The Division of Welfare has established a schedule of charges for dental services covered by the Medicaid program. The claims-processing system, assisted by the computer, determines whether the amount billed by the dentist for the indicated service is within the amount allowed under the State's program. For those services covered by the program,[1] the dentist is paid the lesser of (1) the amount shown on his claim or (2) the amount allowed under the State-established fee schedule.

The above procedures, which are applied to each dental claim processed by the Division of Welfare, are supplemented by additional utilization review controls which are discussed in the following sections.

Payments exceeding prescribed monthly criteria

The Bureau of Medical Services received a report each month listing in summary form information on any dentist whose payments for a month exceeded $500. For each dentist the report shows (1) the number of visits, services provided, and persons receiving the services and (2) the average amount paid for each visit, each service, and each recipient.

Bureau employees review this report to identify dentists whose practices appear to be unusual and, as appropriate, can request detailed printouts of the dentist's past billings. After reviewing the past billings, if it appears

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[1] Effective July 1971 the State found it necessary, because of reductions in State Medicaid funds, to eliminate certain dental services that previously had been covered by the program.

that overutilization exists, the Chief, Bureau of Medical Services will discuss the billings with the dentists. The dentists usually are placed on a list of problem dentists. All services furnished by these dentists are recorded on recipient records so that trends of unsatisfactory service may be developed. When questions arise regarding claims submitted by these dentists that cannot be resolved by bureau employees, the claims are referred to one of two dental consultants for a determination regarding payment of the claims. In September 1971, 16 dentists were on the list of problem dentists.

The Chief, Bureau of Medical Services, advised us that one dentist had been removed from the program because he appeared to be overutilizing the program and because he did not cooperate in correcting the problem.

The bureau also has established procedures to be followed whenever monthly reports show a dentist whose claims exceed $3,000. Prior to releasing a check to such a dentist, the Bureau of Medical Services makes a special analysis of the claims and reports its findings to the director of the Division of Welfare. Only after this analysis is made and after payment is considered proper is the check mailed to the dentist. The November 1971 list showed six dentists who had received over $3,000 for services billed in a 30-day period.

Requirements for prior authorization

The Missouri Medicaid program requires that some dental services be approved by dental consultants before the dental work is accomplished. Dental work exceeding $100, root-canal therapy, and fixed-space maintainers each require prior authorization. Certain high-volume providers are required to obtain prior authorization on any job which exceeds $50 and are required to provide past X-rays on all fillings. Each request for approval of dental work is reviewed by a professional consultant (dentist) who determines whether approval should be given.

Records of dental services provided

The bureau maintains records of permanent dental work, such as extractions, provided to each recipient. Certain temporary services, such as X-rays, teeth cleaning, and denture relinings, also are posted to the record to ensure that such services are not provided more frequently than every 6 months. In addition, all services provided by problem dentists are posted to the recipients' records so that services provided to recipients by these dentists may be reviewed readily.

Bureau employees compare claims received with the recipients' dental records, and, if services provided appear unnecessary, the claims are referred to the dental consultants who determine whether payments should be made.

CONTROLS OVER OTHER NONINSTITUTIONAL SERVICES

The Division of Welfare paid 209 providers about $50,000 for ambulance, laboratory, and X-ray services provided to Medicaid recipients during fiscal year 1971. In September 1971 home health service became a covered service under Missouri's Medicaid program.

Claims for these services are reviewed for eligibility of the recipients and providers. The Missouri Medicaid program requires that providers of laboratory, X-ray, ambulance, and home health services be certified for participation in the Medicare program. Registered nurses and licensed practical nurses may provide home health care to Medicaid recipients when a participating home health agency is not available. The Division of Welfare determines the reasonable charge that will be allowed for such noninstitutional services as clinical laboratory, X-ray, ambulance, and home health care services.

Each claim for ambulance service is reviewed to determine whether the service was provided on an emergency basis. Questionable claims are referred to the physicians' services supervisor for review and disposition. Clinical laboratory and X-ray claims are subject to computer controls to verify that the providers' charges do not exceed the reasonable charges as determined by the Division of Welfare.

EVALUATION OF CONTROLS OVER NONINSTITUTIONAL SERVICES

Many useful controls have been implemented. We believe, however, that each control or group of controls should be analyzed periodically to determine whether it is of continuing benefit to the program. Such analyses may indicate that some controls should be altered or discontinued, that others should be expanded, or that new controls should be adopted.

For example, controls are provided to identify pharmacies where the limitation of an original prescription and six refills in a 6-month period is exceeded. Because payments apparently are made for drugs that exceed the above limitations and because several other controls exist to identify recipients and providers who overutilize the program, we believe that the results realized from this control may not justify continuing it.

Division of Welfare officials agreed that periodic evaluation of their controls would be beneficial, and the director requested his staff to make such evaluations.

The Division of Welfare has effective utilization controls for noninstitutional services. The combination of the general controls applicable to all services and the specific controls applicable to the individual services constitutes an adequate system of controls. During the period that the Missouri Medicaid program has been in effect, the utilization review system has been improved, and as experience is gained the system should produce increasingly useful results.

CHAPTER 5

ADEQUACY OF RESOURCES FOR UTILIZATION REVIEW

The computer section is equipped with an RCA 70 computer and has a staff adequate to operate the computer on a three-shift basis. The Bureau of Medical Services has 85 full-time employees, including two physicians and three registered pharmacists. In addition, four physicians and two dentists are available on a part-time basis.

The following table shows the distribution of manpower resources in the Bureau of Medical Services.

	Employees authorized		Medicaid payments fiscal year 1971		Claims processed fiscal year 1971	
Services	Number	Percent	(millions)	Percent	Number	Percent
Institutional	21	24.7	$31.6	58.5	135,908	4.7
Noninstitutional	64	75.3	22.4	41.5	2,725,486	95.3
Total	85	100.0	$54.0	100.0	2,861,394	100.0

Our review indicated that resources generally were adequate to perform an effective utilization review. Division of Welfare officials told us that they believed that resources were adequate in Missouri to perform an effective utilization review.

CHAPTER 6

THE EXTENT OF ASSISTANCE GIVEN TO MISSOURI BY HEW

Since the Missouri Medicaid program began in October 1967, the Social and Rehabilitation Service has had frequent communications with the Missouri Division of Welfare officials to discuss Medicaid utilization review. A regional official of the Service said, however, that his staff had been unable to adequately assist States in developing utilization review systems because his staff lacked the necessary guidelines or training. Therefore the initiative and efforts of State employees appeared to have a greater impact on the development of the Missouri Medicaid utilization review system than did the assistance and guidance of HEW.

In September 1971 the Service provided Missouri with a model Medicaid Management Information System. The model system--the use of which is optional--is a result of HEW efforts to assist the States in improving the methods they use to administer their Medicaid programs and to correct certain problem areas existing in some States.

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

The model system provides a broad "how to do it" framework within which States can develop detailed system specifications to meet requirements peculiar to their own systems. Within the model system six separate subsystems define and outline the 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) the 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) the review and investigation of deviants to determine whether medical care or services are appropriate or whether misuse has occurred, and (3) the use of appropriate corrective measures in cases involving misutilization.

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, Missouri Division of Welfare officials had not completed their analysis of HEW's model system. They said, however, that the Missouri system appeared to contain most of the key elements of HEW's model system and that some of the detailed data generated under the model system was superfluous.

Although substantive HEW assistance to Missouri in the development of an effective utilization review system has not been timely, the model system provided in September 1971 may offer opportunities for improvement in Missouri's system.

CHAPTER 7

CONCLUSIONS

Missouri appears to have the necessary resources to identify and correct instances of excessive use of medical services. The State has developed a system which includes controls to identify recipients and providers whose use of the program has exceeded established standards. When these recipients and providers are identified, their use of the program is evaluated and, if necessary, restrained.

Missouri's utilization review system does not provide for the systematic accumulation of data (1) showing the amount of reductions in Medicaid costs or other benefits resulting from utilization review and (2) comparing the costs of utilization review with the benefits it provided. We found, however, that Missouri's system was producing positive benefits. Payments to hospitals were reduced about $260,000 over a 1-year period as a result of the disallowance of claims for luxury items or other noncovered services and for excessive lengths of stay. Payments to physicians were reduced about $715,000 over a 1-year period as a result of the disallowance of fees in excess of established maximums.

We believe that the need for continued hospital care should be evaluated earlier than 14 days after a recipient's admission, depending on the average number of days normally required for the illness involved.

We believe also that medical audits of hospitals should be expanded to include more hospitals having high daily costs and/or relatively long average lengths of stay. The benefits obtained from these medical audits, in our opinion, warrant the expansion of effort needed to provide greater coverage.

Periodic evaluations should be made of each control or group of controls so that the more effective controls can be expanded and the less effective controls can be altered, discontinued, or replaced.

Since the establishment of the Missouri Medicaid program in October 1967, HEW and State officials have communicated frequently to discuss utilization review. HEW did not extend substantive assistance to the State until September 1971, however, when it provided Missouri with HEW's model Medicaid Management Information System.

At the conclusion of our fieldwork, State officials had not completed their evaluation of HEW's model system. State officials expressed the view, however, that their system contained most of the key elements of the model system. We believe that, although Missouri has developed an effective utilization review system, HEW's model system may offer opportunities for further improvement and should be studied thoroughly.

INDICATED NEED FOR ACTION BY THE SOCIAL AND REHABILITATION SERVICE

State officials were responsive to our suggestions and agreed to initiate actions aimed at improving their utilization review system. We believe that the Social and Rehabilitation Service should assist the State and should monitor State actions to

--periodically evaluate the effectiveness of utilization review controls,

--expand its utilization review of hospital care,

--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

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