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REPORT TO THE CONGRESS

Improvement Needed In The Administration Of The Iowa And Kansas Medicaid Programs By The Fiscal Agents B-164031(3)

Social and Rehabilitation Service
Department of Health, Education,
and Welfare 44

BY THE COMPTROLLER GENERAL
OF THE UNITED STATES

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COMPTROLLER GENERAL OF THE UNITED STATES
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To the President of the Senate and the
Speaker of the House of Representatives

This is our report on the improvement needed in the administration of the Iowa and Kansas Medicaid programs by the fiscal agents. 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.

A handwritten signature in cursive script that reads "James B. Stacks".

Comptroller General
of the United States

BEST DOCUMENT AVAILABLE

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ABBREVIATIONS

DSS	Department of Social Services (Iowa)
DSW	Department of Social Welfare (Kansas)
GAO	General Accounting Office
HEW	Department of Health, Education, and Welfare

D I G E S T

WHY THE REVIEW WAS MADE

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

Most States contract with private organizations--referred to as fiscal agents--for assistance in administering their Medicaid programs.

The General Accounting Office (GAO) reviewed fiscal agent activities in Iowa and Kansas because the contracts between the States and the fiscal agents provided that significant aspects of the day-to-day operations of the program be carried out by the fiscal agents. During fiscal year 1969, Kansas reported expenditures of about \$36 million for its Medicaid program and Iowa reported about \$32 million. Nationally, about \$4.2 billion was spent under the program; the Federal share was about \$2.2 billion.

FINDINGS AND CONCLUSIONS

GAO found weaknesses in the administration of the Kansas and Iowa Medicaid programs by the fiscal agents and in program monitoring by the responsible State agencies and HEW.

Neither State had established controls adequate for ensuring that Medicaid payments were made only for medically necessary services. Nor had either State provided adequate supervision or review of the administration of the programs by fiscal agents. As a result

- there were indications of overuse of program services and both States experienced lengthy delays in establishing procedures to control such overuse (see pp 14 to 27) and
- although both States had adopted a policy of paying medical practitioners on the basis of customary charges that are reasonable, neither State had ascertained what those charges were for many of the services provided (see pp 29 to 37)

In addition, GAO observed opportunities for improvement in administrative practices relating to

- identification of claims for services that might be covered in whole or in part by the recipient's private health insurance policy (see pp 39 to 43),
- prevention of duplicate payments and payments for medical services provided after the recipient's eligibility had terminated (see pp 44 to 46),
- the filing of paid claims which required the employment of additional staff (see pp 46 to 48), and
- determination of reimbursable costs to participating hospitals (see pp 49 and 50)

There is a need for improved monitoring of the Iowa and Kansas fiscal agents by the responsible State agencies to ensure that the fiscal agents fulfill contractual responsibilities timely and effectively (See pp 53 to 55) There is also a need for improvement in HEW's monitoring of the Iowa and Kansas Medicaid programs to ascertain whether those programs are being administered in an efficient manner and in accordance with approved State plans and Federal policies and regulations (See pp 56 to 59)

GAO believes that the results of its review demonstrate the need for HEW to provide the States with assistance in improving the administration of their Medicaid programs through the provision of guidelines and other information aimed at correcting identified weaknesses

RECOMMENDATIONS OR SUGGESTIONS

GAO is recommending that the Secretary of Health, Education, and Welfare provide the States with.

- Information on methods for reviewing and controlling the use of Medicaid services Model systems should be developed for reviewing the services of major provider groups, including the manner in which reviews by professional medical groups can be used to assist States in controlling the use of Medicaid The States should be required to adopt either the model system or locally developed systems that have been approved by HEW (See p 27)
- Specific guidelines designed to ensure that those States which limit payments for practitioners to customary charges that are reasonable accumulate and use data on charges made by individual practitioners, including, when possible, charges to private insurance programs. (See p 37)

- Guidelines that require the States to provide the agency processing Medicaid claims for payment with the identification of recipients who have private health insurance coverage. The guidelines should also require that processing agencies have procedures to consider private health insurance benefits in determining the amounts to be paid under the Medicaid program. (See p 51)
- Clarification of guidelines on the need for auditing of Medicaid-related data in determining the reasonable cost of hospital care provided to Medicaid recipients. The guidelines should identify specific information to be considered in the audits and should contain instructions regarding the extent to which audits are required to satisfy the criteria of reasonableness. (See p 52)
- Guidelines defining the State agencies' responsibilities relative to fiscal agents' activities and the need for States to provide supervision and review of those activities. (See p. 59)

AGENCY ACTIONS AND UNRESOLVED ISSUES

HEW anticipated that utilization review guidelines would be issued in the near future. HEW informed GAO that, in addition, it had awarded contracts to four States for a pilot medical surveillance and utilization review program. The model system developed through the pilot program is expected to strengthen the ability of States to monitor, plan, and administer the Medicaid program and will be made available for adoption by all participating States. (See p 28)

HEW expressed the view that sufficient guidance was given to State agencies by existing regulations for (1) the accumulation and use of historical charge data including, when possible, charges to private insurance programs and (2) the consideration to be given to private medical insurance coverage in computing amounts to be paid by Medicaid. HEW believed that the weaknesses noted were caused by inadequate implementation by the State agencies. HEW stated that it planned to inaugurate in each regional office a closer monitoring and liaison program with the individual State agencies. HEW informed GAO that it would continue to evaluate its guidelines in light of information obtained through its continuing monitoring of State programs. (See pp 37 and 52)

HEW concurred in GAO's recommendations for clarification of guidelines relating to the need for auditing Medicaid-related data in determining the reasonable cost of hospital care provided to Medicaid recipients and for the issuance of guidelines defining the State agencies' responsibilities relative to fiscal agents' activities and to the need to supervise and review those activities. (See pp 52 and 59)

The actions already taken by HEW should strengthen administration of the Medicaid program. Considering the substantial Federal and State expenditures under the program, prompt attention should be given to the completion of other administrative actions promised.

MATTERS FOR CONSIDERATION BY THE CONGRESS

GAO is sending this report to the Congress because of its interest in the Medicaid program. The report should be useful to the Congress in its consideration of planned legislative changes to the program.

CHAPTER 1

INTRODUCTION

As a part of our continuing interest in the manner in which HEW is carrying out its responsibilities relative to Medicaid, GAO has examined activities of fiscal agents under contract to assist the States of Iowa and Kansas in the administration of their Medicaid programs. 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 in which the Federal Government participates in the costs incurred by the States in providing medical assistance to individuals who are unable to pay for such care.

From inception of the program in January 1966, State Medicaid programs were required to provide inpatient hospital services, outpatient hospital services, laboratory and X-ray services, skilled nursing home services, and physicians' services; effective July 1, 1970, home health care services and screening, diagnosis, and treatment of children also became program requirements. Additional services such as dental care and optical services may be included in its Medicaid program if a State so chooses.

Under Medicaid, States may contract with private organizations for assistance in administering their programs. The functions and responsibilities assigned to the ~~contractors--referred to as fiscal agents--~~vary among the 31 States¹ which use fiscal agents. For example, one fiscal agent may handle only the payment of claims for physicians' services, whereas another may handle almost all of the administrative activities associated with paying for all types of medical care furnished to Medicaid recipients.

Our review of fiscal agent activities was made in Iowa and Kansas because the contracts between the State agencies ^{to administer} administering the programs and the fiscal agents provided that significant aspects of the agencies' day-to-day operations be carried out by the fiscal agents.

¹As of March 1970

As of August 1970, 48 States and four jurisdictions had adopted Medicaid programs. The Federal Government pays from 50 to 83 percent (depending on the per capita income in each State) of the costs incurred by the States under their Medicaid programs. For fiscal year 1969, the States and jurisdictions having Medicaid programs reported expenditures of about \$4.2 billion, of which about \$2.2 billion represented the Federal share. During fiscal year 1969, Kansas and Iowa reported expenditures of about \$36 million and \$32 million, respectively, for their Medicaid programs. The Federal share of the Kansas and Iowa expenditures was about \$18.9 million and \$18.8 million, respectively.

We examined into the HEW policies relating to the use of fiscal agents in Medicaid operations and into the administrative and management practices followed by fiscal agents in fulfilling their contractual responsibilities to the State agencies and into the practices and procedures followed by HEW and the States in monitoring the fiscal agents' activities. We did not evaluate the overall administration or effectiveness of the Medicaid programs in Iowa and Kansas. The scope of our review is described in more detail on page 60.

ADMINISTRATION OF THE MEDICAID PROGRAM

At the Federal level, the Secretary of Health, Education, and Welfare has delegated the ~~responsibility~~ for administering the Medicaid program to the Administrator of the Social and Rehabilitation Service, who administers the program through the Medical Services Administration. The administration is responsible for developing program policies, setting standards, and ensuring State compliance with Federal legislation and regulations. Supplement D, of HEW's Handbook of Public Assistance Administration, and the Services' program regulations provide States with Federal guidelines and instructions for administering the Medicaid program.

Authority to approve grants for State Medicaid programs has been further delegated to the Regional Commissioners of the Social and Rehabilitation Service, who are responsible for the field activities of the program. Under the Social Security Act, the States have the primary responsibility for

initiating and administering their Medicaid programs. 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. The Regional Commissioners are also responsible for determining whether the State programs are being administered in accordance with existing Federal requirements and the provisions of the States' approved plans.

At the time of our fieldwork, the HEW Regional Office in Kansas City, Missouri--one of 10 HEW regional offices--provided general administrative direction for medical assistance programs in Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, and South Dakota.¹ Each of the HEW regional offices has a staff headed by an Associate Regional Commissioner for Medical Services Administration to work directly with State administrators of Medicaid.

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

PERSONS ELIGIBLE FOR MEDICAID

Persons receiving public assistance payments under other titles of the Social Security Act (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) are entitled to benefits of the Medicaid program. Persons whose incomes 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 of the Medicaid program. Those persons receiving public assistance payments are generally referred to as "categorically" needy persons, whereas other eligible persons are generally referred to as "medically" needy persons.

¹Under a realignment of regional boundaries effective July 1, 1970, Minnesota, North Dakota, and South Dakota, will be under the jurisdiction of other HEW regional offices

The Kansas Medicaid program includes both the categorically needy and the medically needy. During fiscal year 1969, there were approximately 97,500 categorically needy and about 33,000 medically needy persons in Kansas who received services or who were qualified for services under the program. During the same period the Iowa Medicaid program included about 75,000 categorically needy ~~Iowa's~~ fiscal year 1969 program also included about 22,000 medically needy persons until February 1969, at which time Iowa discontinued services to the medically needy.

Title XVIII (Medicare) of the Social Security Act (42 U.S.C 1395), provides medical and hospital insurance for most persons 65 years of age and over. Depending upon their financial circumstances, Medicare recipients may also be eligible for assistance under the Medicaid program. Persons eligible for assistance under both programs must exhaust the benefits available under the Medicare program before receiving assistance under the Medicaid program.

CHAPTER 2

IMPLEMENTATION OF THE MEDICAID PROGRAM

AND USE OF FISCAL AGENTS BY KANSAS AND IOWA

The Medicaid program became effective January 1, 1966, however, ^{under the regulations} The States had the option of continuing their medical assistance programs under various other titles of the Social Security Act until January 1, 1970. Since then the Federal Government has participated only in programs established under title XIX.

The Handbook of Public Assistance Administration authorizes the use of fiscal agents by a State agency in the administration of its Medicaid program and sets forth certain provisions that must be included in the contract between the State and a fiscal agent.

KANSAS

The Kansas Medicaid program began in June 1967. The State Department of Social Welfare (DSW) was designated the single State agency responsible for administering the Medicaid program. The Medical Assistance Unit of DSW is the focal point for the Medicaid program.

In addition to providing the basic medical services required by the act (see p. 5), the Kansas Medicaid program provides, among other things, dental services, drugs, and optical services.

DSW contracted with Kansas Hospital Service Association, Inc., and Kansas Physicians' Service for assistance in administering its Medicaid program. These organizations--which, as Medicare intermediaries, provide services to the Medicare program also--are referred to hereinafter as the Kansas fiscal agent. The contract between DSW and the Kansas fiscal agent covered the 3-year period from July 1, 1967, through June 30, 1970. The fiscal agent's responsibilities under the contract included:

1. Development and distribution of informational and instructional materials, including claim forms and manuals, to persons or institutions providing services to Medicaid recipients.
2. Audit and approval of Medicaid claims for payment by the State Department of Administration.
3. Application of procedures specified by DSW for detection of fraud, of unnecessary care, or of other abuses by beneficiaries or providers of service.
4. Development and maintenance of procedures to reveal excess utilization of services or unsound or unethical practices.
5. Provision of specified accounting, statistical, and cost information.
6. Development of a manual describing the fiscal agent's operation.
7. Instruction of providers of service to claim payment from other sources before submitting claims under the Medicaid program.

The contract provided that the fiscal agent be reimbursed for administrative expenses at the rate of \$0.0129 for each dollar of Medicaid claims approved for payment so long as the total reimbursement does not exceed actual expenses. The number of claims, amounts of benefits paid, and the amounts of reimbursement of administrative expenses to the Kansas fiscal agent (based on information supplied by the fiscal agent) are shown in the following table.

	<u>Fiscal Year</u>		
	<u>1968</u>	<u>1969</u>	<u>1970</u>
Number of claims approved for payment	1,426,533	1,722,747	1,625,297
Benefits paid	\$16,965,360	\$26,369,938	\$31,942,314
Reimbursement to fiscal agent (note a)	\$196,991	\$323,643	\$368,571

^aThe amounts of reimbursement do not equal the benefits paid times the \$0.0129 rate because of various adjustments.

Data furnished by the fiscal agent shows that it experienced a loss of about \$1 million during the 3 years of the contract with DSW. We were advised by fiscal agent officials that they would not agree to an extension of the contract because the reimbursement rate did not provide for full recovery of costs.

IOWA

The Iowa Medicaid program began in July 1967. The Iowa Department of Social Services (DSS) was designated the single State agency responsible for administering the Medicaid program. The Bureau of Medical Services of DSS has the primary responsibility for the Medicaid program.

In addition to providing the basic medical services required by the act (see p. 5), the Iowa Medicaid program provides, among other things, dental services, drugs, medical equipment and appliances, and optical services.

DSS contracted with Hospital Services, Inc., of Iowa and Iowa Medical Service for assistance in administering its Medicaid program. These organizations--which as Medicare intermediaries provide services for the Medicare program also--are referred to hereinafter as the Iowa fiscal

agent. The contracts for fiscal years 1968 and 1969 were substantially the same except for the rate of reimbursement to the fiscal agent. The contract for fiscal year 1970 included a further revision of the reimbursement rate and identified more specifically the duties of the fiscal agent. These duties included:

1. Preparation of informational material and billing forms for providers.
2. Audit and payment of claims submitted by providers.
3. Maintenance of records of claims and administrative costs.
4. Provision of accounting and statistical information to DSS.
5. Maintenance of a complete and up-to-date file of all computer programs pertaining to the processing of Medicaid claims.
6. Reviews of services provided by physicians, hospitals, nursing homes, and pharmacies and assistance to DSS in developing a system of review for other Medicaid services.

Statistical data for the Iowa Medicaid program, based on contract terms and information furnished by DSS and the fiscal agent, are as follows:

	Fiscal year		
	<u>1968</u>	<u>1969</u>	<u>1970</u>
Reimbursement rate for each claim handled (note a)	\$0 9082	\$0 92	\$1 19
Number of claims handled	759,061	1,194,190	1,082,141
Benefits paid	\$15,869,379	\$31,029,361	\$22,608,278
Reimbursement to fiscal agent	\$768,383	\$1,228,238	\$1,207,623

^aContracts provide for reimbursement on the basis of claims handled, with a provision for annual adjustment to actual expenses. Any increases to actual expenses are limited to 10 percent of the contract rate.

The principal reasons for decreases in claims handled and benefits paid in fiscal year 1970 from those paid in 1969 are (1) the exclusion of the medically needy from Medicaid coverage, (2) the limitation on payments for hospital care to 10 days for each admission, and (3) the tighter control over payments for skilled nursing home services.

CHAPTER 3

NEED FOR IMPROVEMENT IN CONTROLS OVER

UTILIZATION OF MEDICAID PROGRAM SERVICES

Kansas and Iowa experienced substantial delays in establishing procedures to disclose and control unnecessary utilization of services provided under their Medicaid programs. Effective April 1, 1968, States were required by Federal legislation to establish procedures designed to prevent such unnecessary utilization. Utilization refers to the need, quality, quantity, or timeliness of medical services provided.

Iowa had begun to establish a comprehensive utilization review program in March 1969 and, as of March 1970, had established utilization review procedures for each major category of service. In March 1970 Kansas had established systematic utilization review procedures only for hospitals' and physicians' services. The review procedures established by both States were directed toward identifying overutilization by medical providers. Neither State had established procedures to examine utilization of services by recipients.

The Medicaid program initially did not contain a requirement for a utilization review. The Social Security Amendments of 1967 required that, effective April 1, 1968, State Medicaid plans must provide methods and procedures to safeguard against unnecessary utilization of care and services. In implementing this requirement, the Social and Rehabilitation Service issued an interim regulation on July 17, 1968, which, after minor modification, was issued as a program regulation on March 4, 1969. The regulation specified 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 required that the responsibility for making utilization reviews be placed in the medical assistance unit of the State agency responsible for administration of the program.

Kansas and Iowa have established such units. The Service's regulation, however, does not specify the manner in which these utilization reviews are to be performed, nor does it establish minimum requirements for the provision of a utilization review plan. At the time of our review, the States had not been provided any further guidelines for implementing the March 1969 regulation.

In an April 1969 draft of guidelines relating to utilization reviews, which was sent to the HEW regions for comment, the Medical Services Administration defined a utilization review as any organized activity which evaluates quality, quantity, or timeliness of the medical services provided. The draft 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 the services rendered are based on actual need and to ensure that the frequency of care and service is appropriate to such need. The draft stated further that a utilization review should include (1) a method of evaluating the need for medical services before the services are provided, (2) a determination of the propriety of individual claims, and (3) the accumulation, analysis, and evaluation of claims data identifying patterns and trends of normal and abnormal utilization of services.

The following sections contain our comments on the progress of Kansas and Iowa in developing utilization reviews and the need for further improvements in this area.

KANSAS

Our fieldwork in Kansas was essentially complete by November 1969. At that time the Kansas DSW had not developed a utilization review plan that was required by the July 1968 regulation issued by the Social and Rehabilitation Service. The Director, Medical Services Division, DSW, advised us in July 1969 that he had not completed a utilization review plan because he had been waiting for more definitive guidelines from the Social and Rehabilitation Service. In November 1969 we were advised by the Director, DSW, that the State intended to complete its plan without further instructions.

The contract between DSW and the fiscal agent, entered into in July 1967, required the fiscal agent to (1) develop and maintain methods of audit and analysis of claims which would reveal any excessive utilization of medical services by any beneficiary or provider or an unsound or unethical practice by any provider and (2) assist hospitals in developing utilization review procedures for services provided to inpatient beneficiaries.

At the time of our fieldwork, the fiscal agent had implemented only the following procedures as a means of detecting and controlling possible overutilization of services.

1. Claims for narcotics, drug items costing over \$15, and prescriptions exceeding 300 capsules or 1 gallon liquid, were to be reviewed by the fiscal agent's pharmacy consultant.
2. Prior authorization by consultants or review committees was to be obtained for certain optical and dental services, including orthodontics.
3. Any claims which, in the judgment of the claims examiners, indicated questionable practices or charges by the provider were to be reviewed.
4. Hospital claims were to be referred to a review panel when the number of days of care exceeded criteria established according to diagnosis or when the diagnosis suggested that only custodial care might be required.

Although the fiscal agent had instituted the above measures for review of individual claims, it had not established a comprehensive review process, except for hospital claims, to identify excessive utilization or other abuses by providers or recipients.

Additional comments on the need for improvement of utilization review procedures by the Kansas fiscal agent follow.

Hospital care

The fiscal agent's review of hospital claims as a means of detecting unnecessary services for Medicaid patients began in September 1968. A utilization review panel reviewed both Medicaid and Medicare claims. Records showing the results of these reviews were not available for periods prior to March 1, 1969. During the 3-month period ended May 31, 1969, the panel reviewed 117 Medicaid hospital claims which exceeded established criteria (see item 4 above) and denied payment of about \$8,700 on eight of these claims. During this same period, the panel denied 282 of 2,358 Medicare claims it reviewed, the amount disallowed was about \$124,000. We believe that the benefit of a systematic review of hospital claims is illustrated by the results of the panel's reviews.

In August 1969 DSW instructed the fiscal agent to discontinue its utilization review of Medicaid hospital claims and to reinstate claims previously denied. The Director, DSW, stated that DSW took this action because of its policy which allowed the hospitals final authority over questions concerning the medical necessity of services.

In our opinion, the reviews performed by the fiscal agent's panel indicated that the hospitals' reviews were not completely effective. The Director, DSW, advised us that the policy of allowing hospitals to make the final decision regarding the necessity of the services had not been satisfactory, and in December 1969 DSW regulations were revised to provide that final determinations of medical necessity would be made at the State level. At that time the fiscal agent resumed reviewing hospitals' claims for medical necessity of the service.

Other medical services

A comprehensive plan for review of the medical necessity of drugs and other Medicaid services (such as dental and optical services) had not been developed by the fiscal agent at the time of our fieldwork. Procedures for reviewing selected claims submitted by physicians were implemented in February 1969 for the Medicare program but were not implemented for Medicaid until February 1970. During

the 3-month period ended May 31, 1969, the fiscal agent had reviewed 848 physicians' Medicare claims and denied payments of \$4,535 on 24 claims.

We believe that the following illustrations--while not necessarily typical of the normal pattern of program utilization--indicate the need for systematic surveillance of Medicaid activities

1. Claims for 305 prescriptions were filed for one recipient during the 13-month period ended May 1969. Payments of about \$700 were made to eight pharmacies for these prescriptions. On May 23, 1969, 10 prescriptions were filled by one pharmacy and on May 29, 1969, 11 prescriptions were filled by another pharmacy.
2. In May of 1969, a physician was paid \$1,210 for 401 visits to a nursing home during the period January 2 to March 26, 1969. The physician was visiting the nursing home weekly, seeing from 26 to 34 patients each visit
3. A physician was paid \$780 for 151 hospital visits to one recipient during the 5-month period ended March 31, 1969. This represents about one visit each day. All except the first 4 days of the related hospital claim had been denied by the fiscal agent's utilization review panel on the basis that the patient was receiving only custodial care rather than medical care.
4. A physician was giving injected medication to most of his Medicaid patients in connection with office, home, and nursing home visits. The types of injections was not indicated on the claims. The payments made to this physician in July 1969 included payments for claims of \$4,388 for 512 visits and 644 injections. The charge for each injection was \$3. For some patients a portion of the charges was paid by Medicare. A further breakdown of the visits and injections is shown in the following table.

<u>Place of service</u>	<u>Visits</u>	<u>Visits with injections</u>	<u>Total injections</u>
Office	439	430	564
Home	48	48	58
Nursing home	<u>25</u>	<u>20</u>	<u>22</u>
Total	<u>512</u>	<u>498</u>	<u>644</u>

5. A physician's services under the program consisted principally of outpatient services rendered at a county hospital. The physician was paid about \$32,000 under the program during the 12 months ended July 31, 1969. In some instances this physician charged for inpatient and outpatient visits to the same patient on the same day.

IOWA

The Iowa State plan for Medicaid provides that the State agency, DSS, establish utilization review procedures for each item of care and service furnished under the State's program. The contracts between DSS and the fiscal agent for fiscal years 1968 and 1969 required that the fiscal agent develop methods for reviewing providers' claims that would reveal excessive utilization of medical care or unsound practices by the providers. The contracts did not specify the manner or the extent of utilization review the fiscal agent was to develop. The contract for fiscal year 1970--executed on November 17, 1969--specifies the utilization review procedures to be followed by the fiscal agent in reviewing claims of physicians, hospitals, nursing homes, and pharmacies and provides that the fiscal agent cooperate with DSS in developing utilization review procedures for services furnished by dentists, podiatrists, optometrists, opticians, and chiropractors.

During most of the first 2 years, the fiscal agent's utilization review was limited to individual claims which appeared questionable in the judgment of the fiscal agent's claims examiners. Formal or systematic utilization review procedures were not employed for any services until March 1969, at which time a review to determine medical necessity was initiated for nursing home claims. In June and July 1969, formal review procedures for hospital, home health agency, and physicians' claims were implemented. Utilization review procedures for drug claims were initiated in December 1969 and for dental claims in March 1970.

The Social and Rehabilitation Service regional office staff, in a June 1968 internal report, noted that DSS was awaiting Federal criteria and guidelines prior to implementing utilization review procedures. The Director, Bureau of Medical Services, DSS, advised us in March 1970 that DSS had been reluctant to develop a utilization review program on the basis of legislation or an interim regulation because the final regulation could have required substantial changes in the utilization review program.

DSS arranged with various professional medical groups, such as the Iowa Medical Society and the Iowa Dental Association, to assist, in an advisory capacity, in the administration of the Medicaid program. These groups assist DSS by (1) reviewing selected providers' claims referred to them by DSS and advising DSS of potential overutilization or other abuses of the program and (2) advising DSS on criteria to be used by the fiscal agent in selecting and reviewing claims for possible overutilization.

Additional comments on the utilization review procedures of the Iowa fiscal agent follow.

Physicians' services

The fiscal agent began a utilization review of physicians' claims for Medicaid payments on July 1, 1969, basically following the plan developed for the Medicare program. The utilization review of physicians' claims by the fiscal agent consists of the following three phases.

1. The examiner reviews claims upon receipt and refers those exceeding specified criteria (for example, claims for more than five injections per month) to a utilization review group for further consideration of reasonableness before payment.
2. Postpayment reviews are made of claims which exceed established parameters. (For example, X-ray or lab claims exceeding \$100 for a recipient in a 6-month period.)
3. Random sample selections are made of paid claims for the purpose of mailing questionnaires to recipients to verify that services were received.

The second and third phases of the utilization review of physicians' claims did not begin until February 1970.

In July 1969, at the request of DSS, the Iowa Medical Society began a review of the activities of the 14 physicians who had received over \$15,000 under the Medicaid program during calendar year 1968. In October 1969 the

Society reported to DSS that it had analyzed claims for 20 percent of the Medicaid patients served by each of the 14 physicians. The Society reported that its reviews included a thorough assessment of the claims submitted for care rendered to the Medicaid patients, personal meetings with the physicians, and evaluation of other available material. They reported that (1) no evidence of overutilization or other abuses of the program was found in eight of the 14 cases, (2) there was sufficient evidence of overutilization or other abuses by four physicians to justify consideration by DSS of a hearing to determine the physicians' future role in the program, and (3) there was sufficient evidence of overutilization or other abuses of the program by two physicians to justify consideration by DSS of placing all future claims by these physicians under surveillance.

In December 1969 the Commissioner, DSS, notified each of the six physicians that a review by the Bureau of Medical Services, with the assistance of the Iowa Medical Society, had revealed numerous instances of overutilization. Following are examples of the medical services questioned by DSS and the Iowa Medical Society.

Physician A

1. Claims were submitted for nursing home visits although there was not any evidence in the nursing home records that the visits were made.
2. Claims were submitted for office visits although the patients had never been to the office. Specifically, charges were made for 127 office calls in 1968 for six patients, none of whom had been to the office.
3. There was a general pattern of excessive visits and prescriptions for medication in view of the diagnosis for and condition of the patients.

Physician B

1. Drugs were dispensed in excessive amounts in view of the diagnosis for and condition of the patients.

2. The type and frequency of laboratory tests performed were inappropriate in view of the diagnosis.
3. Charges for services rendered to Medicaid recipients exceeded charges made to private patients for similar services.
4. Office and nursing home calls were excessive in view of the diagnosis for and condition of the patients.

DSS placed the six physicians on probation and directed the fiscal agent to scrutinize all future claims submitted by these physicians. In December 1969 DSS also requested the advice of the State Assistant Attorney General as to whether the evidence obtained from the Iowa Medical Society's review, of claims submitted by physicians A and B above, would support suspension from the program and whether the evidence would be sufficient to support prosecution for fraud. In a letter dated June 12, 1970, commenting upon a draft of this report, DSS advised HEW that action had been taken to suspend the two physicians from the program and that a fraud investigation was being undertaken by the State law enforcement agency.

Skilled nursing care

Prior to March 1969, DSS permitted the payment of claims submitted for any Medicaid recipient residing in a skilled nursing home without determining the need for such care. Effective March 1, 1969, DSS revised its policy to provide that there must be a showing of medical need for the service before payment would be made.

To implement this policy, DSS required skilled nursing homes to submit a form containing certain medical information in support of each claim for skilled care provided. The information to be submitted included a diagnosis of the patient's condition, any physical limitations, and the physician's orders. Officials of DSS stated that, with this information, the fiscal agent could, in most instances, determine whether skilled nursing care provided was medically necessary. ?

If the fiscal agent determined that the skilled nursing care provided was not medically necessary, DSS policy allowed payment to be made through the month in which such determination was made. For example, a claim for skilled nursing care provided during the month of September would normally be received in October. If the fiscal agent then determined that the care provided was not medically necessary, the DSS policy nevertheless allowed payment for such care to be made for September and October.

If officials of a skilled nursing home questioned the decision of the fiscal agent, the fiscal agent would review the case and any additional medical data submitted by the nursing home. On the basis of this review, the fiscal agent would either reaffirm or reverse its original determination.

DSS and the fiscal agent did not maintain readily accessible records of those cases for which the fiscal agent made uncontested determinations that skilled nursing care was not required. DSS maintained a file of those cases for which an appeal was made and for which the fiscal agent reaffirmed its original decision. During the period June 1969 through January 1970, 394 reaffirmations were made. We examined the records of 85 reaffirmations made during December 1969 and estimated that, for these cases, payments of about \$82,000 were allowed for 222 months of skilled nursing care which the fiscal agent determined to be medically unnecessary. Had these patients been placed in a nonskilled nursing home or in a custodial care home, the cost for their care for the 222 months would have been about \$40,000. These costs, however, would have been paid under federally assisted programs other than Medicaid.

We did not estimate the total financial impact of the DSS policy because records of cases for which the fiscal agent had made uncontested determinations that skilled nursing care was not required were not readily accessible. In April 1970 DSS revised its policy for payment for skilled nursing care and provided that payment be made only through the last day for which skilled nursing care was determined to be medically necessary.

Hospital care

Since June 1969 claims for hospital care have been reviewed by the fiscal agent's claims examiners and those claims that did not meet criteria regarding diagnosis or length of stay were referred to medical personnel employed by the fiscal agent for their determination of the medical necessity for the care. Prior to that time, no utilization review of hospital services was performed.

The contract for fiscal year 1970 between DSS and the fiscal agent requires the fiscal agent to review at least 10 Medicaid patient cases quarterly for each hospital participating in the Medicaid program for which the fiscal agent is also the Medicare agent (intermediary). We were advised by the fiscal agent that the purpose of reviewing these cases was to determine whether the hospitals' utilization review committees were functioning as described in their utilization review plans. The fiscal agent is the Medicare intermediary for 110 of the 150 Iowa hospitals participating in the Medicaid program and therefore 40 hospitals are not subject to review by the fiscal agent. We found that the Iowa fiscal agent, in its capacity as Medicare intermediary, was reviewing the operations of hospital utilization review committees but was not reviewing any Medicaid cases.

Drugs

In December 1969, the fiscal agent began recording data from selected pharmacists' claims to accumulate information on recipients' drug purchases and on pharmacy practices. Claims were selected by the fiscal agent on the basis of specific criteria, such as those claims exceeding \$50 for one recipient or claims for seven or more prescriptions filled for a recipient in 1 month. The data accumulated was to be reviewed by pharmacy consultants, beginning in March 1970, for indications of overutilization or other abuses. Prior to December 1969 the fiscal agent did not make a systematic utilization review of pharmacy claims.

The Iowa Pharmaceutical Association began reviewing pharmacy claims in July 1969. At the request of DSS, the Iowa Pharmaceutical Association reviewed selected claims

involving prescriptions filled by all 25 pharmacies which received over \$25,000 under the Medicaid program in 1968. The Association reported to DSS on August 29, 1969, that (1) contrary to Iowa Medicaid regulations, some pharmacies were not obtaining physicians' approvals before refilling prescriptions and (2) one pharmacy was billing for prescription drugs in some instances when nonprescription drugs were actually dispensed. The Association suggested that DSS might want to investigate further the activities of three pharmacies.

In January 1970 DSS was still reviewing the detailed information submitted by the Association and decisions had not been made regarding possible action against any of the pharmacies discussed in the Association's report.

Dental services

In March 1970, the fiscal agent began a postpayment review of dental claims to identify unnecessary program utilization of dental services. The claims reviewed were selected on the basis of established criteria, such as payments to a dentist for supplying complete dentures to more than four recipients during a 1-month period. The criteria were recommended by the Iowa Dental Association and approved by DSS.

In July 1969 the Iowa Dental Association Council on Dental Care Programs began a utilization review of the claims involving services provided by the 17 dentists who had received over \$12,000 under the Medicaid program in 1968. In a report dated October 2, 1969, the Council recommended complete surveillance of billings by one dentist, a limited surveillance of billings by four dentists, and a field audit and complete surveillance of all billings by three dentists. The report also recommended that patient education and postoperative treatment be deleted from coverage under the Medicaid program as these services were subject to overutilization. The report stated that, although it was not a usual practice for dentists to charge for showing educational films to patients, one dentist routinely billed for this service.

The Director of the Bureau of Medical Services, DSS, stated that the dental manual would be revised to exclude patient education and postoperative treatment from covered services. He stated also that the recommendations of the Council concerning the eight dentists would not be acted on until DSS obtained more information from the Council.

CONCLUSION

Iowa and Kansas experienced lengthy delays in establishing procedures to control the utilization of Medicaid services. For some services utilization review procedures were not implemented until early 1970, and for other services procedures had not been developed at the time we completed our fieldwork in April 1970.

We believe that the problems experienced in establishing and implementing utilization review procedures were 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. We found that in both States progress in establishing and implementing utilization review procedures was slow because State officials were awaiting further instructions and guidance from HEW. Although a draft of guidelines relating to utilization reviews was sent for comments to HEW regions in April 1969, such guidelines had not yet been finalized and issued.

RECOMMENDATION TO THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE

In view of the need for assistance to the States in the area of utilization reviews, we recommend that the Secretary of Health, Education, and Welfare provide the States with information on methods for reviewing and controlling utilization of Medicaid services. Model systems should be developed for reviewing the services of major provider groups, including the manner in which reviews by professional medical groups can be used to assist States in controlling utilization. The States should be required to adopt either the model system or locally developed systems which have been approved by HEW.)?

AGENCY COMMENTS AND ACTION

By letter dated August 17, 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 Iowa and Kansas, who generally concurred with our findings. (See app. I.)

HEW advised us that final publication of utilization review guidelines, which have been in draft form for quite some time, had been delayed because the guidelines are under consideration by HEW's task force on Medicaid and related programs. (See p. 58.) The task force's final report, 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 Medicaid program effectiveness systems designed to control program utilization. HEW stated that it hoped to issue utilization review guidelines in the near future.

HEW informed us that, in addition, it had awarded contracts for the implementation of a pilot medical surveillance and utilization review program with four States-- Colorado, Oklahoma, Rhode Island, and West Virginia. HEW stated that the model system developed through this pilot project was expected to strengthen the ability of States to monitor, plan, and administer the Medicaid program and that the system would be made available for adoption by all participating States.

CHAPTER 4

PROBLEMS FOUND IN DETERMINING

PRACTITIONERS' REASONABLE CHARGES

Kansas had established controls, through its fiscal agent, designed to ensure that payments for all practitioner services, other than dental, were reasonable and did not exceed the practitioner's customary charges. Iowa had established such controls for only physicians' services. Legislation in both States and Federal regulations require that Medicaid payments to practitioners be limited to customary charges which are reasonable.

The Social Security Act requires that State Medicaid plans provide methods and procedures for ensuring that payments for care and services are not in excess of reasonable charges consistent with efficiency, economy, and quality of care. Social and Rehabilitation Service regulations issued in January 1969 require that payment for services provided by individual practitioners be limited to customary charges which are reasonable.

Iowa and Kansas have adopted a policy that medical practitioners be paid on the basis of their customary charges, provided that the charges do not exceed reasonable amounts for the type of services provided. Neither Iowa nor Kansas, however, had ascertained the customary charges for many of the services provided by practitioners. As a result, the States could not determine whether the amounts paid by the fiscal agents for these services exceeded the individual practitioners' customary charges. Although in some cases customary-charge data was available, the fiscal agents were not using this information to limit payments to practitioners.

We believe that, to comply with the Service's regulations and their State plans, Iowa and Kansas should develop information on practitioners' customary charges for all types of services covered under the Medicaid program. Such information could be obtained from prior charges under the Medicaid, Medicare, and private health insurance programs.

Such data could be used by the fiscal agents to help ensure that payments to practitioners do not exceed customary charges.

Both Iowa and Kansas have established a policy of limiting payments for practitioners to reasonable charges. The reasonableness of a charge for a particular medical service is determined on the basis of the prevailing charges--those charges most frequently and most widely made in a locality for a particular medical service. Although both States have established prevailing charges on this basis for some practitioners, Kansas had not done so for dentists and Iowa had not done so for practitioners other than physicians.

Also Iowa had not complied with the HEW requirement that approval be obtained from the Secretary of Health, Education, and Welfare for increases in charges for services. The Social and Rehabilitation Service regulation dated July 1, 1969, requires that payment for services provided by physicians, dentists, and other practitioners under the Medicaid program be limited to the lesser of (1) amounts being allowed under Medicaid as of January 1, 1969, or (2) amounts being allowed under Medicare at that date. This regulation was issued as part of an effort by HEW to control the increasing costs of medical care. In April and December 1969, Iowa increased the amounts allowable for certain services of physicians. Approval of these increases was not obtained from the Secretary although the Service's regulation froze amounts allowable at the January 1, 1969, level.

These matters are discussed in detail in the following sections.

IOWA

The Iowa Medicaid plan provides for customary and reasonable charges to be paid for practitioners' services. The State defines a reasonable charge as the charge that is customary but not in excess of the prevailing charge in the locality for similar services. The State plan defines a customary charge as the amount which the individual practitioner charges for the particular service in the majority of cases. The plan provides also that the prevailing charge be the upper limit.

The State plan does not require practitioners to register their customary charges with the fiscal agent. The fiscal agent has developed data on actual charges for only physicians and, using this data, has established individual physicians' customary charges and prevailing charges.

In November 1967 the fiscal agent developed data on customary and prevailing charges for surgical procedures for participating physicians on the basis of charges previously made under Medicare and the fiscal agent's private insurance program (Blue Shield). This data, or profile, was updated in March 1968 and again in December 1968. In this latter revision, Medicaid program charges were used in updating the profile. This profile was last revised in September 1969.

Although the fiscal agent developed data on customary and prevailing charges for surgical procedures in November 1967, it did not use the customary data--but did use the prevailing data--in processing Medicaid claims until September 1969, or almost 2 years later. Data on both the customary charge and the prevailing charge was used by the fiscal agent beginning in November 1967 in processing Medicare claims for payment. Thus Medicare payments were limited to the least of the (1) actual charge, (2) customary charge, or (3) prevailing charge. On the other hand Medicaid payments were limited to only the lesser of the actual or the prevailing charge. As a result, payments made under Medicaid were sometimes higher than those made under Medicare for the same surgical procedure. This was contrary to the DSS contract with the fiscal agent because the contract provided that Medicaid payments to physicians be based on the same data as Medicare payments.

Our review of selected Medicaid surgical claims processed by the fiscal agent prior to September 1969 revealed instances in which overpayments had occurred because the fiscal agent's approval of the claims was not based on customary-charge data. Our review of 34 surgical claims showed that the fiscal agent had been able to establish valid customary charges for services for only 17 of these claims. We found that, of the remaining 17 claims where customary charges had been established, overpayments had been made in seven cases, as follows:

<u>Amount claimed</u>	<u>Established customary charge</u>	<u>Amount paid</u>	<u>Amount in excess of customary charge (overpayment)</u>
\$300	\$200	\$300	\$100
300	200	300	100
200	175	200	25
225	200	225	25
225	175	185 ^a	10
150	100	110 ^a	10
110	80	105 ^a	25

^aThese claims were reduced to coincide with prevailing charges or because of a disallowance for other reasons by the fiscal agent's medical staff.

A fiscal agent's representative advised us that data on customary charges had not been used as the basis for approving Medicaid claims prior to September 1969 because there was insufficient staff to compare amounts claimed to customary charges. From September to December 1969, these comparisons were made manually. In December the fiscal agent began to use electronic data processing equipment to make such comparisons.

As of January 1, 1969, the fiscal agent had developed and placed into effect a prevailing charge schedule for nonsurgical services for both the Medicaid and the Medicare programs. The charges had been established in July 1968 on the basis of the judgment of the fiscal agent's medical staff and not on the basis of the charges most frequently made. In April 1969 the fiscal agent--again on the basis of the judgment of its medical staff--placed into effect a new prevailing charge schedule. The new schedule showed increases in the prevailing charges for nine of the 50 nonsurgical services and decreases for 14.

Although the July 1, 1969, Federal regulation called for a freeze on payments for physicians' services at levels in effect on January 1, 1969, DSS did not seek approval from HEW for the April increases nor did it require the fiscal agent to rescind the increases. An official of the fiscal agent stated that, although the increases should

have been approved by HEW or rescinded, the charge schedule had been used as the basis for approving Medicare and private insurance claims and that he did not consider it feasible to establish a separate schedule for Medicaid. The Director, Bureau of Medical Services, DSS, advised us that, until we brought the matter to his attention, he had not been aware that the fiscal agent had made the April 1969 revisions to its charge schedule.

In December 1969 the fiscal agent developed a revised schedule of prevailing charges for nonsurgical services under the Medicaid and Medicare programs on the basis of actual charges made to the Medicare program and to the fiscal agent's private insurance program during calendar year 1968. This action was taken to comply with the Social Security Administration's instructions that prevailing charges for services under Medicare were to be based on actual charges. As mentioned previously, Iowa's charge schedule had been established on the basis of the judgment of the medical staff of the fiscal agent.

The Director, Bureau of Medical Services, DSS, told us that he had interpreted the Federal regulation of July 1, 1969, as permitting increases in fees for physicians' services if the increases were based on charges made prior to January 1, 1969. He said that, since the December 1969 revisions were based on 1968 data, he did not consider it necessary to obtain HEW approval for these increases. The July 1969 regulation was an attempt by HEW to control the rising costs of medical services by freezing payments to practitioners. The regulation makes no provision for updating customary or prevailing charges without HEW approval and specifies that the payment levels in effect on January 1, 1969, govern.

The following schedule illustrates some of the increases in the fiscal agent's December 1969 revised schedule of prevailing charges for nonsurgical services.

	<u>Prevailing charges</u>	
	<u>Jan. 1969</u>	<u>Dec. 1969</u>
Routine injection	\$ 3	\$ 5
Injection in joint	10	11
Extended hospital visit (per day)	25	41

Since DSS and the fiscal agent had not developed customary-charge data for practitioners other than physicians, maximum charges (in lieu of prevailing charges) were established for these practitioners by DSS with the assistance of the professional medical groups. For example, maximum charges for dental services were established on the basis of recommendations by a committee of the Iowa Dental Association. Thus the fiscal agent had no assurance that payment for services of practitioners other than physicians was limited to the practitioners' customary charges.

KANSAS

The Kansas Medicaid plan provides that the basis of payment for medical services by practitioners be customary charges as registered with the fiscal agent. The plan limits payments to prevailing charges developed from the customary charge registrations of each practitioner group (physicians, dentists, podiatrists, etc.). In addition, DSW's contract with the fiscal agent limits payments under Medicaid for physicians and podiatrists to customary and reasonable charges allowable under Medicare.

The fiscal agent had obtained registrations from some physicians under its private insurance program and from chiropractors and some optometrists under the Medicaid program. DSW had authorized the fiscal agent to approve payment of claims submitted by practitioners who had not registered their customary charges but had limited such payments to the maximum established by the fiscal agent for the services rendered. As a result, payments were made to numerous practitioners without assurance that the payments did not exceed customary charges to the general public for similar services.

The Kansas fiscal agent used three methods in establishing the maximum charges payable for a particular service. Maximum charges were established on the basis of (1) the registered charges, when sufficient numbers of registrations were received, (2) a study by the Kansas Medical Society, which included the assignment of point values to medical services, a dollar value then being applied to the assigned points by the fiscal agent, or (3) the judgment of professional medical groups and/or the fiscal agent.

As of October 1969, about 1,800 of the 2,125 Kansas physicians participating in the Medicaid program, or about 85 percent, had registered their customary charges or their customary-charge data was available from the Medicare program. A fiscal agent's official advised us that the agent planned to obtain the customary-charge data for the remainder of the participating physicians. We also noted that the fiscal agent did not have customary-charge data for any of the 1,987 out-of-State physicians who had made claims under the Kansas Medicaid program. We recognize that it

would be impracticable to obtain customary-charge data for all of these physicians. We believe, however, that such data should be obtained for those physicians who regularly serve Kansas Medicaid recipients.

Although customary-charge data was available to the fiscal agent for most Kansas physicians, the fiscal agent had not established procedures for determining whether the amounts charged by the physicians for injections and home and office visits (the most frequently claimed services) exceeded the customary charges for these services. We reviewed claims for these services provided during April, May, and June 1969 by six physicians whose charges, we noted, were in excess of their customary charges. Our review showed that overpayments amounting to \$1,357 had been made.

Fiscal agent representatives advised us that actual charges claimed for injections and home and office visits were not compared with customary charges because the frequency of claims for these services was too great, considering available staff, to permit the comparisons to be made under its manual system. As a result of our discussions, in November 1969 the fiscal agent began to compare actual charges claimed with customary charges on a sample basis to identify those physicians whose actual charges were in excess of their customary charges. As of March 1970, the fiscal agent had identified 199 physicians and/or clinics.

For medical practitioners other than physicians and chiropractors, neither registrations nor profiles were being used to ascertain whether the practitioners' actual charges exceeded their customary charges. Although DSW had requested optometrists to register their customary charges for certain services, the registrations received had not been put in a usable form and consequently were not being used as a basis for approving claims for payment. We were advised by representatives of the fiscal agent that attempts had been made to obtain registration of customary charges for dental services under a private insurance program but that the response had not been sufficient to be of any value.

CONCLUSION

HEW regulations require that payments to practitioners not exceed customary charges which are reasonable, and both Iowa and Kansas Medicaid plans provide for paying medical practitioners on this basis. Iowa, however, had not ascertained the customary charges for services (other than physicians' services), and Kansas had not ascertained the customary charges for dental services. Also, in some cases where charge data had been obtained, it was not being used to determine the reasonableness of charges. Further, there were instances in which charge data was not accumulated for individual practitioners under Medicaid or other programs, but charges were established on the basis of the judgment of the fiscal agent or from data supplied by professional medical groups. In these instances, there was no assurance that payments were limited to the customary and reasonable charges.

RECOMMENDATION TO THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE

HEW regulations regarding Medicaid payments to practitioners do not provide any guidelines to the States as to how to assemble charge data. We therefore recommend that the Secretary of Health, Education, and Welfare provide the States with specific guidelines designed to ensure that States, which limit payments for practitioners to customary charges that are reasonable, accumulate and use historical charge data of individual practitioners, including, when possible, charges to private insurance programs.

AGENCY COMMENTS AND ACTION

In a letter dated August 17, 1970 (see app. I), from the Assistant Secretary, Comptroller, HEW, in commenting on a draft of this report, HEW expressed the view that its existing regulations relating to the accumulation and use of historical charge data were sufficient guidance for the various State agencies. It was HEW's opinion that the weaknesses noted in Iowa and Kansas had been caused by inadequate implementation of the regulations by the responsible State agencies.

HEW stated that it planned to inaugurate, through its regional offices, a closer monitoring and liaison program with the individual State agencies. HEW stated also that, under this program, it planned to have a closer relationship with the State agencies and to make more frequent visits and detailed reviews of State operations. HEW informed us that it would, however, continue to evaluate the adequacy of its existing guidelines relating to the accumulation and use of historical charge data in the light of information obtained through its continuing monitoring of State programs.

CHAPTER 5

OPPORTUNITIES FOR IMPROVEMENT IN

OTHER ADMINISTRATIVE PROCEDURES

Our tests of randomly selected claims paid by the Iowa and Kansas fiscal agents indicated a need for (1) additional administrative controls designed to reduce payment errors and (2) improvement in the practices being followed by the fiscal agents or the States. These matters relate to

- identification of claims for services that might be covered in whole or in part by the recipient's private health insurance policy (Iowa and Kansas),
- prevention of duplicate payments (Iowa and Kansas) and payments for medical services provided after the recipient's eligibility had terminated (Iowa),
- the filing of paid claims which required the employment of additional staff (Iowa), and
- determination of reimbursable costs to participating hospitals (Iowa and Kansas).

In most instances the State agencies and the fiscal agents had taken or had been considering corrective action at the time we completed our review. We believe that reviews of the fiscal agents' claims-processing activities by the State agencies would have resulted in timely identification and correction of these administrative weaknesses. The areas listed above are discussed in greater detail in the following sections of this chapter.

IDENTIFICATION OF PRIVATE INSURANCE OBLIGATIONS

The Social Security Act requires that State medical assistance plans provide that all reasonable measures be taken to ascertain the legal obligation of third parties--including private insurance companies--to pay for medical services. The act requires also that such third-party responsibilities

be treated as a resource of the Medicaid recipient. Both the Iowa and the Kansas State plans provide for the identification of such resources.

A Social and Rehabilitation Service program regulation issued in January 1969 implementing the legislative requirement restates the law but does not provide specific guidelines to the States as to how they should ascertain the insurance coverage of Medicaid recipients.

Medicaid payments were being made in both Iowa and Kansas for medical services which were covered by private insurance carried by Medicaid recipients. In many cases the providers received payments for the same services from Medicaid and from private insurance companies and then voluntarily refunded the amount of the insurance proceeds for credit to the Medicaid program

Records maintained by DSW showed that, during the first 2 years of the Medicaid program, about \$210,000 was refunded by providers. About \$96,000 was specifically identified as amounts received from private insurance companies. About \$66,000 in refunds was identified as other types of overpayments, however, our tests indicated that many of these other overpayments were, in fact, refunds from providers who had received payments from a private insurance company and under the Medicaid program. Consequently it appears that at least half of all refunds were related to receipts of payments from private insurance companies.

Providers refunded about \$494,000 to the Iowa fiscal agent during the first 2-1/2 years of the Medicaid program. The fiscal agent notifies DSS of each refund and identifies the reason for each refund (such as payment by private insurance company, payment to wrong provider, and duplicate payment). The fiscal agent does not maintain summaries of the total refunds relating to payments by private insurance companies. We estimated, however, that, of the \$494,000 refunded about \$94,000 was refunded because of payments received from private insurance companies.

We did not have a reasonable basis for estimating the additional amount of private insurance proceeds that providers (1) might not have refunded to the Medicaid program.

and (2) could have obtained in lieu of Medicaid funds had they known that the Medicaid recipients had private insurance coverage.

Iowa

Application for Medicaid is made at the county welfare offices. The application form provides space for information on the applicant's private medical insurance coverage. Applicants determined to be eligible are given Medicaid identification cards which are to be presented to providers when the recipient obtains services. If private insurance is carried by the recipient, a special-colored card is issued to him. The county office advises the fiscal agent monthly of the persons who are eligible for Medicaid. This information shows whether the recipient has private medical insurance coverage.

Iowa has a further control procedure to help ensure that Medicaid payments are reduced by amounts recovered under Medicaid recipients' private insurance. Before a provider submits a claim to the fiscal agent for services rendered to a Medicaid recipient whose identification card shows that he has private insurance coverage, the provider must advise the county welfare office of the amount, if any, received from such a private source. The county office then authorizes the provider to submit its claim. If the fiscal agent receives a claim without an authorization, its processing system will reject the claim when the eligibility check shows that private insurance is available.

Iowa's control procedures should be adequate for preventing the unnecessary expenditure of Medicaid funds in those cases where a Medicaid recipient's private insurance has been identified as a resource. We found, however, that the eligibility information provided to the fiscal agent by the county welfare office showed only that the head of a family had such insurance coverage. The fiscal agent's processing system therefore would not reject claims for services provided to other members of the family who might also be covered by the policy. For example, if a physician treated the head of a family and the children and submitted claims to the fiscal agent without an authorization from the county welfare office, the fiscal agent's processing

system would reject the claim for the head of the family but would not reject the claims for the children

After we brought this matter to the attention of DSS officials, they revised the eligibility records to identify each family member covered by insurance.

Kansas

In Kansas, county welfare offices and the providers have been advised by DSW that, if recipients have private medical insurance, the amounts available from such insurance must be used to pay for medical expenses before claims are submitted under the Medicaid program. The claim forms provide space for deducting amounts received or recoverable under private medical insurance.

The DSW eligibility records furnished to the fiscal agent did not show whether Medicaid recipients had private insurance coverage. Prior to January 1970, the recipient's identification card did not indicate to providers that the recipient had private medical insurance. Also, even though all claims were processed through county welfare offices before submission to the fiscal agent, some counties did not determine whether providers had made any claims against their private medical insurance before the claims were forwarded to the fiscal agent for payment.

At the time of our fieldwork in Kansas, the fiscal agent was accumulating a card file on individual recipients who had--according to information shown on claims forms--private medical insurance. This file was incomplete and was not being used by the fiscal agent to determine whether providers had sought reimbursement from the private insurance. The card file included data on about 2,000 individuals.

From this file we selected 65 individuals whose cards showed that they had private insurance coverage under Blue Cross-Blue Shield (the Kansas fiscal agent), and compared the Medicaid payments for services rendered with payments available or made under the private insurance policies. This comparison showed that Medicaid payments had been made for services provided to 16 individuals without adequate

consideration of their private insurance coverage. For example, charges of about \$250 had been paid under both the Medicaid program and the Blue Cross-Blue Shield insurance. Also, charges of about \$1,200 had been paid under Medicaid which should have been paid in whole or in part by Blue Cross-Blue Shield.

After we brought these matters to the attention of DSW, the Director sent a letter to each county welfare director and to each provider reiterating the importance of seeking payment from private insurance companies. The Director advised us that, where applicable, the individual Medicaid recipient's identification card for 1970 would show the name of the private insurance company. Also, we were advised in April 1970 by the Administrative Assistant, DSW, that DSW was planning a revision in the routing of Medicaid claims which would require providers to submit claims directly to the fiscal agent rather than to the county office for review.

Including data about a Medicaid recipient's private medical insurance on his identification card should be an aid to providers in identifying those recipients who have private medical insurance. Because of DSW's plans to have providers submit claims directly to the fiscal agent, controls should be established by the fiscal agent to ensure that providers consider Medicaid recipients' private insurance resources before submitting the claim.

PREVENTION OF DUPLICATE PAYMENTS

Iowa

DSS and the fiscal agent had been aware as early as October 1968 that numerous duplicate payments were being made as a result of weaknesses in the fiscal agent's procedures. A continuing review of paid claims by DSS regularly disclosed duplicate payments. Voluntary refunds from providers who were paid more than once for the same service also indicated that there was a need for corrective action.

Early in the program the fiscal agent established procedures designed to prevent duplicate payments of regular Medicaid claims but did not establish such procedures for claims in which the beneficiary was also eligible for Medicare benefits (Medicare-related claims). Medicare-related claims are first submitted to the Medicare intermediary for payment. That amount not covered by Medicare (the deductible and coinsurance) is then claimed under the Medicaid program. Although DSS and the fiscal agent were aware that duplicate payments were occurring on Medicare-related claims, action to correct the situation was not taken until February 1970.

Our review of selected refunds of duplicate payments showed that the fiscal agent's automated procedures for detecting duplicate claims for regular Medicaid cases permitted certain claims previously paid to be processed for payment again. These were cases in which it previously had been necessary to assign a bypass code to a claim to effect its payment. The bypass code would be assigned when a preliminary manual review of a claim showed that more than one service was rendered to a recipient on the same day (for example, an office visit and an injection). In the automated system, such a claim would be rejected unless a code was assigned which would permit the claim to bypass the automated check. If a duplicate claim was subsequently processed, it would not be rejected by the computer because a bypass code for these services had previously been entered into the system.

Our review of refunds of duplicate payment showed also that some duplicate payments had occurred because claims

examiners, without having performed adequate reviews to ensure that the claims had not previously been paid, placed bypass codes on claims which had been rejected by the automated system as possible duplicate claims. Fiscal agent officials advised us that action to improve their procedures designed to detect duplicate claims had been or would be taken.

In January 1970 the fiscal agent initiated a postpayment review of claims designed to detect duplicate payments. This review disclosed that, during the first 2-1/2 years of the program, duplicate payments of \$355,000 had been made, of which \$103,400 pertained to Medicare-related claims. The review also showed that \$85,000 of the duplicate payments had been refunded. The fiscal agent planned to recover the remainder of the duplicate payments after verifying the amounts due from individual providers.

In February 1970 the fiscal agent implemented revised prepayment procedures for detecting duplicate claims. The revised procedures are applicable to Medicare-related claims as well as to regular Medicaid claims.

Kansas

The fiscal agent's procedures for preventing duplicate payments for physicians' services provide for the automated computer system to compare the type and dates of service as shown on claims being processed for services rendered to Medicaid recipients with the same type of data shown on claims paid previously. In instances where the comparison showed that the same type of services had been provided on more than one date (for example, three office visits in a month), only the first date of service was entered into the computer system. As a result, the computer contained incomplete records of dates of service, which limited the effectiveness of the procedures to detect duplicate claims.

The fiscal agent had established service codes for physicians' hospital visits to Medicaid recipients. The last two digits of the codes indicate the physicians' diagnosis. The service codes were assigned by claims examiners on the basis of the diagnosis shown on the physicians' claim forms. The examiners, however, often had to use judgment

in determining the proper code to be assigned to a diagnosis. We noted that the same code was not always assigned for the same diagnosis, which limited the effectiveness of the procedures to prevent duplicate payments. In the processing of physicians' claims for Medicare, the same service code was used for all hospital visits.

We brought this matter to the attention of fiscal agent officials who advised us that procedures would be issued requiring that all service dates be entered into the computer and requiring that the same service code be used for all hospital visits.

PAYMENT FOR SERVICES BEYOND ELIGIBILITY DATE

Our review of the Iowa fiscal agent's automated computer procedures for verifying Medicaid recipients' eligibility showed that recipients were considered to be eligible for hospital, nursing home, and home health agency services for 1 month after their eligibility for Medicaid had terminated. Although our review did not reveal that any payments had been made for services provided to a recipient beyond the period of eligibility, the procedures would permit such payments to be made.

After we pointed this out to the fiscal agent, the eligibility verification procedures were revised to ensure that payments would not be made after recipients' eligibility terminated.

EMPLOYMENT OF STAFF FOR FILING PAID CLAIMS

Our comparison of the staff employed by the Iowa and Kansas fiscal agents showed that the Iowa fiscal agent had employed substantially more people to file paid claims. The number of filing clerks used by the two fiscal agents and the number of claims filed are shown in the following table.

<u>State</u>	Number of file clerks (<u>Nov. 1969</u>)	<u>Number of claims filed</u>	
		<u>Fiscal year 1968</u>	<u>Fiscal year 1969</u>
Iowa	12 ^a	625,351	1,076,515
Kansas	1	1,426,533	1,722,747

^aEquivalent full-time personnel based on six full-time and 10 part-time clerks. The number of part-time clerks was increased to 15 in March 1970.

We examined into the filing methods used by the two fiscal agents. The claim filing method used by the Iowa fiscal agent was specified in its contract with DSS. An identification number is assigned to each case, and usually all recipients in the same family are identified by the same case number. Claim folders are made up by the fiscal agent for each case number and are filed in numerical sequence, by county. Claims paid for each member of the family are filed in the appropriate folder. The filing process requires considerable time since the correct claim folder must be located before each claim can be filed.

The Kansas filing method consists of filing paid claims by provider categories in the sequence in which the claims were processed. Each claim is stamped with a sequence number which is used as a control number in the electronic data processing system. To file the claims, the clerk places the claims (usually in batches of 100) grouped by provider category in file drawers for each provider category.

The Iowa fiscal agent acting in its capacity of fiscal intermediary for Medicare began, in October 1969, to convert from filing Medicare physicians' claims on a recipient basis (as is done for Medicaid) to a sequence number basis (as is done in Kansas for Medicaid). An official stated that this action was taken after a visit to the offices of the Kansas Blue Shield showed that it was filing Medicare claims on a sequence number basis, with substantially fewer people. The intermediary in Iowa had 16 Medicare filing clerks in September 1969 but had reduced the number to two by April 1970.

DSS officials advised us that an evaluation of the fiscal agent's filing system for Medicaid claims would be made to determine whether it would be economically feasible to change to a sequential number filing system or to some other less costly system.

AUDIT OF REIMBURSABLE COSTS OF HOSPITALS

Kansas DSW and Iowa DSS have not established audit procedures to ensure that reimbursements for hospital care represent the reasonable cost of providing care to Medicaid patients. Payments to hospitals comprise a significant portion of the total costs of the Medicaid program. Under HEW regulations hospitals are to be paid for services provided to Medicaid recipients on a reasonable cost basis in accordance with Medicare principles of reimbursement.

According to HEW's definition, reasonable costs of inpatient hospital services means the reimbursable portion of allowable costs incurred in serving Medicaid recipients. This takes into account that all allowable costs applicable to each patient shall be borne by the patient or by the program designated as responsible for payment of hospital charges made to the patient.

In March 1969 the Commissioner, Medical Services Administration, issued a memorandum to the States authorizing the use of audited Medicare cost information in determining the reasonable costs for services provided to Medicaid patients. The memorandum provides, however, that the States make a limited audit of hospital services related to the Medicaid program which are not covered by the audit for the Medicare program. The memorandum stated that a common Medicare-Medicaid audit program was being developed by HEW. As of March 1970 a common audit program had not been provided to the States.

The contract between DSW and its fiscal agent provides that the fiscal agent may use the Medicare audits of hospital costs for Medicaid or the fiscal agent may review independent hospital reports in determining the reasonable cost of services provided. The contract between DSS and its fiscal agent provides that the fiscal agent be responsible for audits in determining costs reimbursable to hospitals and states that Medicare cost statements and audits be used in making the Medicaid audits.

At the time of our fieldwork, only about half of the audits had been made of hospital costs incurred under the Medicare program in Kansas and Iowa for fiscal year 1967.

Substantially fewer Medicare audits for fiscal year 1968 had been completed. The Medicare audits include a determination of (1) the hospitals' total costs, (2) the total charges to all patients, and (3) allowable costs under the Medicare program allocated to Medicare patients on the basis of Medicare charges and Medicare patient-days. The Medicare audits do not include a review of data relating to Medicaid patient care such as

--charges, number of patient-days, and interim reimbursements and

--adjustments for insurance recoveries or billing errors.

We found that the fiscal agents in both States had accumulated, for each hospital, data relating to Medicaid charges, patient-days, interim reimbursements, and payments received from other sources as shown on the claims. The Kansas fiscal agent furnished this data to the hospitals for use in preparing their annual cost settlement statements. The Iowa fiscal agent used this data, along with total hospital cost data obtained from the Medicare audit, to prepare the hospitals' cost settlement statements. The fiscal agents permitted the hospitals to use the data or reports furnished by the fiscal agents or data from their own records in preparing cost settlement statements. Whichever method was used, the fiscal agents did not verify the accuracy of the Medicaid-related data.

We believe that ~~some verification~~ of Medicaid-related data is needed. For example, we found that the data prepared by the Kansas fiscal agent did not include complete information relating to payments received by the hospitals from other sources and did not include adjustments resulting from refunds made by the hospitals.

Officials of DSW and the fiscal agent expressed the opinion that the State's audit responsibility relating to Medicaid was being fulfilled and that additional audit had been unnecessary.

The Director, Bureau of Medical Services, DSS, stated that the need for audit of Medicaid-related data would be considered and discussed with HEW regional officials.

CONCLUSION

In reviewing the administrative procedures of the fiscal agents, we noted that improvements were needed to ensure that duplicate payments were not made and that payments were not made for services provided after the date a recipient's eligibility had terminated. We noted also that improvements were possible in the matter of filing paid claims. These weaknesses are principally related to the activities of the State and/or the fiscal agent. Other weaknesses, however, indicated a need for additional direction from HEW. *These such as* related to (1) consideration of payments for services by private insurance companies in determining amounts reimbursable from Medicaid and (2) audits of Medicaid-related data in determining the reasonableness of hospital costs.

HEW regulations relating to payments by private insurance companies for services provided to Medicaid recipients require that States determine the extent to which third parties will pay for medical services but do not provide any guidance regarding how this is to be done. HEW regulations provide that States, in making final settlements with hospitals for the reasonable cost of service provided to Medicaid patients, may use the cost information developed during the Medicare audit of a hospital, provided that the State makes a limited audit of Medicaid-related data pertaining to services not included in the Medicare audit. These regulations, however, do not identify the specific information to be considered in such limited audits or define the extent to which audits are required.

Conclusion?

RECOMMENDATIONS TO THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE

Because of the weaknesses which we noted in the administrative procedures of the fiscal agents in Iowa and Kansas, we recommend that the Secretary of Health, Education, and Welfare provide the States with:

- Guidelines that require the States to provide the agency processing Medicaid claims for payment with the identification of recipients who have private health insurance coverage. The guidelines should also require that processing agencies have procedures

to consider private medical insurance benefits in determining the amounts to be paid under the Medicaid program.

- Clarification of guidelines on the need for auditing of Medicaid-related data in determining the reasonable cost of hospital care provided to Medicaid recipients. The guidelines should identify specific information to be considered in the audits and should contain instructions regarding the extent to which audits are required to satisfy the criteria of reasonableness.

AGENCY COMMENTS AND ACTION

In a letter dated August 17, 1970 (see app. I), from the Assistant Secretary, Comptroller, HEW, in commenting on a draft of this report, HEW advised us that it would issue clarifying guidelines relating to the need for auditing Medicaid-related data in determining the reasonable cost of hospital care provided to Medicaid recipients.

With regard to our recommendation for guidelines relating to the identification and use of private medical insurance coverage, HEW expressed the view that its existing regulations were sufficient guidance for the various State agencies and that the weaknesses noted had been caused by inadequate implementation of the regulations by the State agencies. HEW stated that it planned to inaugurate, through its regional offices, a closer monitoring and liaison program with the individual State agencies. HEW stated also that, under this program, it planned to have a closer relationship with the State agencies and to make more frequent visits and detailed reviews of State operations. HEW informed us that it would, however, continue to evaluate the adequacy of its existing guidelines relating to the use of private medical insurance coverage in the light of information obtained through its continuing monitoring of State programs.

CHAPTER 6

NEED FOR IMPROVED MONITORING

OF MEDICAID PROGRAMS

MONITORING BY STATE AGENCIES

There is a need for improved monitoring of the Iowa and Kansas fiscal agents by the State agencies to ensure that the fiscal agents have fulfilled contractual responsibilities timely and effectively. We believe that comprehensive reviews of the Iowa and Kansas fiscal agents' activities would have shown a need for increased effort by the fiscal agents

- to develop and implement methods of claims review for detecting cases in which unnecessary medical services had been provided,
- to develop data on customary and prevailing charges and to use it in reviewing claims submitted by practitioners, and
- to improve their claims processing procedures.

Also DSS had not ascertained whether the fiscal agent's administrative costs were adequately supported and reasonably necessary in the performance of its contract, even though claimed costs were in excess of the interim reimbursement rate established by the contract. The Iowa fiscal agent was reimbursed for all costs claimed during the first 2 contract years.

The HEW Handbook of Public Assistance Administration, although authorizing the use of fiscal agents, does not provide guidelines or methods to be followed by State agencies in their administration of contracts with their fiscal agents. The handbook requires that the State agencies submit their contracts with fiscal agents to HEW but does not require approval of the contracts by HEW.

Iowa

DSS had assigned a full-time auditor to review Medicaid claims paid by the fiscal agent. The auditor, however, had not been given review guidelines to follow. The reviews consisted primarily of determining whether data shown on the claims was complete, whether mathematical computations were correct, and whether the claims had been previously paid. DSS officials advised us that the auditor was not responsible for determining the causes of the weaknesses or deficiencies in operating procedures which resulted in any overpayments. Since March 1970, DSS has had two auditors reviewing claims paid by the fiscal agent.

Although the auditor prepared monthly reports on the audit results, the reports were generally limited to listings of the amounts and types of overpayments found. The reports were furnished to the fiscal agent for review and for collection of the overpayments.

Periodic meetings have been held between DSS and its fiscal agent since the inception of the Medicaid program. Also in early 1970 the DSS data processing director reviewed some of the fiscal agent's computer programs. Except for the audits of claims, however, DSS has not regularly or systematically monitored the fiscal agent's activities.

Because of the need to be better informed about the fiscal agent's operations, in January 1970 DSS proposed to the fiscal agent that DSS place a full-time liaison person in the fiscal agent's offices. The fiscal agent suggested that the fiscal year 1971 contract make provision for such a position.

Kansas

DSW's monitoring of its fiscal agent consisted of (1) periodic meetings between officials of the two organizations, (2) a prepayment review of claims approved by the fiscal agent to help ensure that payments did not exceed maximum amounts allowable, and (3) a limited review by the DSW medical audit section of claims approved by the fiscal

agent. The medical audit section reviews were not performed on a systematic basis; rather they were performed generally on a trouble-shooting basis. Reports were not prepared on the results of any of the reviews, and communications between DSW and the fiscal agent concerning the reviews generally were not documented.

DSW did not have any staff assigned to the fiscal agent's offices to monitor or review operations. Also DSW had not ascertained whether the procedures being followed by the fiscal agent were adequate to fulfill its contractual responsibilities. For example, the 3-year contract awarded in 1967 required the fiscal agent to develop and maintain a manual describing its operations, however, a fiscal agent official advised us that such a manual would not be available before July 1970.

MONITORING BY HEW

Our review showed also a need for improvement in the monitoring of the Iowa and Kansas Medicaid programs by HEW to ascertain whether they were being administered efficiently and in accordance with approved State plans and Federal policies and regulations. In previous sections of this report, we discussed several weaknesses which we noted in the Iowa and Kansas programs. We believe that these weaknesses could have been corrected timely had HEW effectively monitored these programs.

The HEW Region VI Medical Services Staff was responsible, at the time of our fieldwork, for Federal administration of the Medicaid programs in Iowa, Kansas, and five other States. The professional staff consisted of an Associate Regional Commissioner and two assistants. The functions of this staff included assistance to the State agencies in

- developing medical services plans and programs in accordance with Federal Medicaid legislation,
- developing procedures for the evaluation and reporting on the operation of the programs,
- interpreting HEW policies and procedures issued to implement Federal legislation, and
- informing State agency officials of nationwide trends and developments in medical services.

We were advised by the Associate Regional Commissioner that, effective July 1, 1970, the regional offices would also have primary responsibility for evaluation of State Medicaid programs. He stated that the program review and evaluation projects being conducted jointly by HEW Central and Regional Office officials would be discontinued.

Monitoring of the Iowa and Kansas Medicaid programs by the HEW regional Medical Services Staff consisted principally of reviewing State plan material and other program information submitted by the States and making field visits to the States to observe and discuss the operation of the programs. Field visits were generally limited to 1 or 2 days.

We reviewed the reports available from inception of the States' programs in mid-1967 through March 15, 1970, and found reports on only five visits to Kansas and nine to Iowa. The regional officials stated that reports were not always prepared.

Also Region VI representatives assisted in an HEW Central Office program review and evaluation project in Kansas in November 1968 and in Iowa in April 1969. In addition, during the period March 22, to April 2, 1968, an HEW team of Central and Regional Office representatives made a survey of public assistance programs (including Medicaid) administered by DSW.

The HEW regional Medical Services Staffs' field visits did not include comprehensive evaluations of the effectiveness of the programs or their administration. The Associate Regional Commissioner advised us that the region had been unable to make comprehensive evaluations because of limited staff and limited travel funds. In July 1969 he proposed to the Medical Services Administration of the Central Office that the professional Medical Services Staff in the region be increased by six staff members to permit adequate monitoring of the Medicaid programs in the region's seven States.

The reports on the field visits and reviews by HEW regional representatives showed that they were aware of some of the weaknesses in the Iowa and Kansas programs which are discussed in this report. The reports did not, however, show the basic causes of the weaknesses or what specific corrective actions were needed. The regional officials advised us that they did not routinely request States to respond to the findings noted during their field visits or reviews nor did they always follow up to determine whether corrective actions had been taken by the States.

The HEW report on the November 1968 program review and evaluation in Kansas stated that the only significant weakness in methods for controlling unnecessary utilization of medical services was related to nursing homes. A report on a June 1969 visit to Kansas by an HEW regional representative, however, stated that Kansas was still in the process of developing State plan material concerning utilization

review methods. Prior to February 1970, Kansas had not established a systematic utilization review method for any services except hospital care. An HEW regional official stated that action by Kansas to establish utilization review procedures had been delayed because of the lack of specific Federal guidelines defining requirements of a utilization review program.

An HEW regional representative's report of a June 1968 visit to Iowa stated that DSS had not taken formal action to comply with Federal requirements for utilization reviews. The report stated also that DSS was awaiting Federal criteria and guidelines. A report on a visit in June 1969 (1 year later) showed that DSS still had not established a program to control unnecessary utilization but that during the visit regional representatives had discussed with DSS officials methods which might be used in establishing a utilization review program. By March 1970, DSS had established utilization review procedures for all major services provided under its Medicaid program.

Reports on HEW reviews of the Iowa and Kansas Medicaid programs did not indicate that any evaluations had been made of the manner in which the States complied with State and Federal regulations concerning limitations on payments to medical practitioners. Each State had adopted a policy requiring that Medicaid payments be limited to practitioners' customary and reasonable charges. HEW regional officials advised us that staffing limitations had prevented the region from conducting the type of review necessary for evaluating whether State payments met the requirements of State plans and related Federal requirements.

An HEW task force's November 1969 interim report on Medicaid and related programs also indicated a need for substantial improvement in HEW's monitoring of the States' administration of Medicaid programs. 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 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.

CONCLUSION

HEW has not issued guidelines defining the States' responsibilities when contracting with fiscal agents to assist them in the administration of their Medicaid programs. Although both Iowa and Kansas had contracted with fiscal agents for periods which began July 1, 1967, neither State had made any comprehensive reviews of their fiscal agents' activities during the period covered by the contracts to ensure that the fiscal agents had fulfilled their contractual responsibilities. We believe that HEW should emphasize to the States the need to perform continuing and comprehensive reviews of the activities of their fiscal agents.

RECOMMENDATION TO THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE

We recommend that the Secretary of Health, Education, and Welfare provide the States with guidelines defining the State agencies' responsibilities relative to fiscal agents' activities and the need for States to provide supervision and review of these activities.

AGENCY COMMENTS AND ACTION

In a letter dated August 17, 1970 (see app. I), the Assistant Secretary, Comptroller, HEW, in commenting on a draft of our report, concurred in our recommendation that HEW issue guidelines defining the State agencies' responsibilities relative to fiscal agents' activities and to the need for States to provide supervision and review of these activities.

CHAPTER 7

SCOPE OF REVIEW

Our review of the administration of the Medicaid programs in Iowa and Kansas was directed to an evaluation of program administration that these States had assigned to their respective fiscal agents. We reviewed the activities of the fiscal agents under contract to assist the States in administration of the programs of the State public assistance agencies responsible for the programs in Iowa and Kansas, and of HEW.

Also we (1) reviewed pertinent legislation and Federal regulations, contracts between State agencies and fiscal agents, State plans for providing medical assistance, and other pertinent data, (2) examined claims submitted for payment for medical services provided under the program, and reviewed the operating procedures followed by the fiscal agents in processing claims for payment, and (3) reviewed the extent of advice and assistance provided to the State agencies by the HEW regional staff and the extent of similar services provided to the fiscal agents, and control exercised, by the State agencies

A significant portion of our fieldwork was accomplished in the offices of the Kansas and Iowa fiscal agents in Topeka, Kansas, and Des Moines, Iowa. We also worked at the State offices of DSW and DSS in these same cities and at the HEW Regional Office in Kansas City, Missouri

APPENDIXES



DEPARTMENT OF HEALTH EDUCATION AND WELFARE
WASHINGTON D C 20201

AUG 17 1970

OFFICE OF THE SECRETARY

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

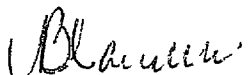
Dear Mr Heller:

The Secretary has asked that I reply to the draft report of the General Accounting Office on its Review of Administration of the Medicaid Program and the Use of Fiscal Agents by the States of Iowa and Kansas.

Enclosed are the Department's comments on the findings and recommendations in your report, including where appropriate, reference to comments obtained from the Department of Social Services of the State of Iowa and the State Department of Social Welfare of the State of Kansas.

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

Sincerely yours,


James B Cardwell
Assistant Secretary, Comptroller

Enclosure

COMMENTS ON GENERAL ACCOUNTING OFFICE DRAFT REPORT
REVIEW OF ADMINISTRATION OF THE
MEDICAID PROGRAM AND THE USE OF FISCAL
AGENTS BY THE STATES OF IOWA AND KANSAS

The draft report of the General Accounting Office presents a factual picture of the situation in Iowa and Kansas, with regard to program administration and the use of fiscal agents, and is consistent with the findings of the SRS Regional Office on these subjects

Comments obtained by us from officials of the States of Iowa and Kansas generally concurred with the findings reported and discussed a number of actions which State officials have taken or plan to take to improve the administration of their Medicaid programs. These comments, which are rather lengthy, have not been attached. We are pleased to note that the State agencies found the General Accounting Office report to be helpful and that they have given and are continuing to give considerable attention to the matter of utilization review.

The report recommends that the States be provided with certain information, guidelines, and clarification of existing guidelines.

The first recommendation relates to the provision of information on methods for reviewing and controlling utilization of Medicaid services. The recommendation states that model systems should be developed for reviewing the services of major provider groups, including the manner in which reviews by professional medical groups can be used to assist States in controlling utilization and that the States should be required to adopt either the model system or locally developed systems which have been approved by HEW.

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 Medicaid 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 and third recommendations relate to the provision of specific guidelines designed to ensure that States, which limit payments to practitioners to their customary charges which are reasonable, accumulate and use historical charge data of individual practitioners, including wherever possible, charges to private insurance programs, and to the provision of guidelines which require that States provide to the agency which is processing Medicaid claims for payment, the identification of recipients who have private medical insurance coverage and which requires that processing agencies have procedures to consider the private medical insurance benefits in calculating payments on Medicaid claims.

We believe that existing handbook regulations are sufficient guidance for the various State agencies and that the cause of the weaknesses noted is inadequate implementation by the State agencies. These deficiencies are not unique with Iowa and Kansas, but have been noted by the HEW Audit Agency in almost all the States they have reviewed. We feel that these deficiencies will be lessened and hopefully eliminated, by a closer monitoring and liaison program with the individual State agencies soon to be inaugurated 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, however, continue to evaluate the adequacy of these guidelines in light of information brought to our attention through our continuing monitoring of State programs. In the meantime we will also consider other approaches to overcome these troublesome areas.

We agree with the fourth and fifth recommendations. The fourth recommendation relates to providing States with clarification of guidelines on the need for audit of Medicaid-related data in determining the reasonable cost of hospital care provided to Medicaid recipients. The recommendation states that the guidelines should identify specific information in need of audit and instructions regarding the extent to which audit is required to satisfy the criteria of reasonableness. The fifth recommendation relates to the provision of guidelines defining the State agency responsibility relative to fiscal agents' activities and the need for States to provide supervision and review of these activities.

BEST DOCUMENT AVAILABLE

As soon as possible, we plan to issue clarifying instructions to the State agencies on the above points, and follow-up on actions taken through our regional reviews. We estimate that we will be able to accomplish the actions we plan to take on these matters within the next 12 months.

BEST DOCUMENT AVAILABLE

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

	<u>Tenure of office</u>	
	<u>From</u>	<u>To</u>
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 REHA- BILITATION 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