REPORT TO THE COMMITTEE ON WAYS AND MEANS HOUSE OF REPRESENTATIVES

12

Functioning Of The Maryland System For Reviewing The Use Of Medical Services Financed Under Medicaid B-164031(3)

Social and Rehabilitation Service

Department of Health, Education, and Welfare

BY THE COMPTROLLER GENERAL OF THE UNITED STATES

DEC. 21, 1972

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

B-164031(3)

Dear Mr. Chairman:

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

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

Sincerely yours,

Elmer B. Staats

Comptroller General
of the United States

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

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

B-164031(3)

Dear Mr. Chairman:

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

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

Sincerely yours,

Elmer B. Staats

Comptroller General
of the United States

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

CONTENTS

ABBREVIATIONS

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

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

FUNCTIONING OF THE MARYLAND SYSTEM FOR REVIEWING THE USE OF MEDICAL SERVICES FINANCED UNDER MEDICAID

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

D I G E S T

WHY THE REVIEW WAS MADE

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

Background

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

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

This report covers the utilization review system followed in Maryland. GAO reports on the systems followed in Missouri, Florida, and Massachusetts were issued on March 27, 1972; June 9, 1972; and November 24, 1972, respectively.

Medicaid is a grant-in-aid program administered by the Department of Health, Education, and Welfare (HEW). The Federal Government shares with States the cost of providing medical care to persons unable to pay for such care. The Federal share in each State depends upon the per capita income of the State. In Maryland the Federal share of Medicaid in fiscal year 1971 was 50 percent.

Congressional concern over rising Medicaid costs led to amendments to the Social Security Act in 1967 that required each State to include a system to review the uses of Medicaid.

In this series of reports, GAO is evaluating general review controls applicable to all medical services and specific controls applicable to institutional and noninstitutional medical services.

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

FINDINGS AND CONCLUSIONS

During fiscal year 1971 Maryland paid about $93 million for benefits furnished to about 298,000 Medicaid recipients. The Federal share was about $46 million. (See pp. 10 and 11.)

DEC. 21, 1972

Tear Sheet

The Medical Care Programs Administration of the State Department of Health and Mental Hygiene is responsible for administering the Maryland Medicaid program, including the utilization review system. The Administration has not developed a written review plan prescribing (1) how reviews are to be made, (2) the services to be reviewed, (3) the criteria to be used in identifying questionable or deviant cases or patterns of care, and (4) the actions to be taken to correct inappropriate care or overuse of the Medicaid program. However, with respect to institutional services, some rather strict review requirements are being used. (See p. 13.)

No separate organization within the Administration is responsible for review. Instead, review activities are fragmented among separate program sections. (See p. 13.)

Maryland's utilization review system does not provide for the systematic accumulation of data showing the claims reviewed and approved or disapproved and the amounts of reductions in claims. The availability of such data would enable management officials to (1) identify the providers who repeatedly file unreasonable claims and the recipients who repeatedly overuse the program so that their participation in the program may be restrained or stopped, (2) analyze overutilization of medical services for the purpose of identifying general trends and provide a basis for developing methods of avoiding such overutilization, and (3) make cost-benefit analyses of review activities. (See p. 14.)

Controls applicable to all Medicaid services

Maryland has established procedures to determine that claims paid are

--for services rendered by eligible providers to eligible recipients,

--for services of the kind authorized by the program, and

--limited to amounts established by the State.

The claims processing system does not include procedures for identifying or preventing duplicate payments. (See p. 17.)

Controls applicable to Medicaid institutional services

Of the $93 million paid by Maryland for Medicaid services in fiscal year 1971, about $76 million, or 82 percent, was for institutional services principally in nursing homes and hospitals. (See p. 18.)

Preauthorization (approval of services before they are provided) for admission to skilled nursing homes and for extensions of hospital care and skilled nursing-home care provides control over the use of institutional services. (See p. 28.)

Hospitals and nursing homes participating in Maryland's Medicaid program are required to have a review plan that provides for a committee, consisting of at least two physicians, to review (1) the medical necessity of admissions, duration of stays, and professional services furnished and (2) each case of extended stay. GAO's

examination of State records applicable to selected hospitals and nursing homes participating in the Medicaid program showed that these institutions had review plans and were complying with their plan requirements. (See pp. 18 and 19.)

Medical reviews of skilled nursing-home care have been effective in identifying patients inappropriately placed for the level of care required. However, there was no followup to see that corrective action had been taken. (See p. 22.)

Controls applicable to Medicaid noninstitutional services

Payments for physician services and pharmaceutical services, the principal noninstitutional services, amounted to about $13 million, or 77 percent, of the $17 million spent by the Maryland Medicaid program for noninstitutional services. (See p. 24.)

Review of noninstitutional services is provider oriented. Deficiencies found and corrective actions taken generally relate to claims by providers, especially physicians. Increased attention to program use by recipients would provide a means of controlling the use of medical services and would enhance the benefits obtained from review. (See p. 29.)

Recipient and provider histories should be developed and measured against established norms of service to assist in identifying cases of possible overutilization. (See p. 29.)

Except for physician services, review consists primarily of preauthorization activities and the review of invoices questioned during claims processing. There is no ongoing program to regularly identify for review those providers or recipients who exceed the usual or average limits of service. (See p. 29.)

Some procedures have been established to control the use of noninstitutional medical services. However, effectiveness of these controls and procedures and the results of review cannot be determined or evaluated because, for the most part, records are not maintained. Such records should show (1) the providers who are identified for review because of questionable claims for payment or apparent excessive use of medical services, (2) the review actions taken to identify incorrect claims or overuse of services, and (3) the corrective measures taken in cases involving incorrect claims or overutilization. (See p. 29.)

State officials informed GAO that a written utilization review system was being developed. They said that the system would include control over questioned cases and would provide information on the review actions taken and on case disposition. (See p. 30.)

GAO believes the State, in developing its utilization review system, should insure that provision is made for

--a program of review for each noninstitutional service available under the program and

--the use of parameters or limits of service to assist in identifying for review the providers and the recipients who exceed the usual limits of services. (See p. 30.)

Tear Sheet

Adequacy of State resources

State officials said that the State had the necessary computer capability and funds for developing a review system. State officials believe that, under the current system, a lack of sufficient personnel for making reviews is their biggest problem.

A request for seven additional positions (doctors, nurses, and clerical employees) to expand review activities was included in the Medical Care Programs Administration's fiscal year 1973 budget request. This request was denied. The Administration plans to again ask for additional positions in its fiscal year 1974 budget request. (See p. 31.)

The ability of the State to implement the review system it is developing will depend upon the amount of funds made available by the State legislature. (See p. 31.)

Extent of assistance by HEW

Review activities under Maryland's Medicaid program began in 1968 and have developed into the current utilization review system. Development of the various review activities resulted from the State's initiative rather than from specific assistance by HEW.

In October 1971 HEW provided Maryland with a model management information system providing a broad framework within which the State could develop detailed system specifications to meet requirements peculiar to its own system. GAO was informed that about 98 percent of what was advocated in the HEW system had already been considered in a management information system being developed for the State. GAO believes HEW's model system may offer Maryland opportunities for improving its utilization review system and should be studied thoroughly. (See pp. 32 and 33.)

RECOMMENDATIONS OR SUGGESTIONS

HEW should assist the State and should monitor State actions to:

--Develop an effective utilization review system.

--Make a thorough comparison of HEW's model system and the management information system being developed for the State and include provisions for utilization review, to adopt the provisions which could best meet the needs of the State.

--Provide for the systematic accumulation of data required by management officials to efficiently administer utilization review activities. (See p. 36.)

CHAPTER 1

INTRODUCTION

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

As requested by the Committee, we inquired into the

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

--results achieved under the utilization review system;

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

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

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

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

This is the last of four GAO reports on methods followed by States in reviewing the use of medical services financed

under Medicaid. Our reports[1] on the utilization review systems followed in Missouri, Florida, and Massachusetts were issued in March, June, and November 1972.

DESCRIPTION OF MEDICAID PROGRAM

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

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

Services provided to Medicaid recipients vary from State to State. All States must provide certain basic medical services required by law; that is, inpatient and outpatient hospital care, laboratory and X-ray services,

---

[1] Report to the Committee on Ways and Means, House of Representatives, on "Functioning of the Missouri System for Reviewing the use of Medical Services Financed Under Medicaid" (B-164031(3), Mar. 27, 1972).

Report to the Committee on Ways and Means, House of Representatives, on "Functioning of the Florida System for Reviewing the Use of Medical Services Financed Under Medicaid" (B-164031(3), June 9, 1972).

Report to the Committee on Ways and Means, House of Representatives, on "Functioning of the Massachusetts System for Reviewing the Use of Medical Services Financed Under Medicaid" (B-164031(3), November 24, 1972).

skilled nursing care for persons 21 years of age or older, home health services for persons entitled to skilled nursing care, screening and treatment for persons under 21 years of age, and physician services. Transportation is required by HEW regulation. Additional services--such as dental care, prescribed drugs, eyeglasses, and care for patients 65 years of age or older in institutions for mental diseases and/or for tuberculosis--may be included if a State so chooses.

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

ADMINISTRATION OF MEDICAID PROGRAM

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

The Regional Commissioners determine whether the State programs adhere to the provisions of the approved State plans and to Federal policies, requirements, and instructions contained in HEW's Handbook of Public Assistance Administration and in program regulations. The Regional Commissioner in the Service's regional office in Philadelphia, Pennsylvania, provided general administrative direction for the Medicaid program in Maryland.

The HEW Audit Agency is responsible for auditing the manner in which Federal and State responsibilities for the Medicaid programs are discharged. The HEW Audit Agency has not reviewed Maryland's utilization review system.

PERSONS ELIGIBLE FOR MEDICAID

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

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

REQUIREMENTS FOR UTILIZATION REVIEW

In fiscal year 1965, before Medicaid began, total Federal-State medical assistance expenditures under the federally assisted programs authorized by the Social Security Act amounted to $1.3 billion. Under Medicaid such expenditures increased rapidly and amounted to about $3.5 billion in fiscal year 1968.

Congressional concern over rapidly rising Medicaid costs led to legislative action in 1967. As a result, an amendment to the Social Security Act required, effective April 1, 1968, that each State Medicaid plan provide methods and procedures (utilization review systems) to safeguard against unnecessary utilization of medical care and services to insure that payments are not in excess of reasonable charges consistent with efficiency, economy, and quality care.

---

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

HEW implementation

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

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

Because there are 52 widely differing medical assistance programs under Medicaid, the language of the regulation is quite broad and permits States considerable latitude in their approach to utilization reviews. The regulation does not specify the manner in which utilization reviews are to be made and does not establish minimum requirements for utilization review plans.

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

The draft guidelines stated also that utilization reviews should include (1) methods to review needs for medical services before services were provided and (2) reviews to determine the propriety of individual claims and to accumulate, analyze, and evaluate claims data to identify patterns and trends of normal and abnormal use of services.

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

MARYLAND'S MEDICAID PROGRAM

Maryland started its Medicaid program on July 1, 1966. The program provides benefits to both categorically and medically needy persons. During fiscal year 1971, Maryland provided Medicaid services to about 298,000 persons.

In addition to providing the basic Medicaid services described on page 6 , Maryland provides numerous additional services, including

--dental services;

--pharmaceutical services;

--care for persons 65 years of age and over in tuberculosis and mental hospitals;

--special services, such as vision care, podiatry, and ambulance; and

--payment of Medicare insurance premiums for Medicaid recipients aged 65 or over.

The following table shows, by category of medical service, the total number of persons served and the total Medicaid program expenditures for fiscal year 1971.

Medicaid services	Fiscal year 1971 Persons served	Fiscal year 1971 Payments (000 omitted)
Institutional:		
Inpatient hospitals	48,227	$30,923
Outpatient hospitals	159,597	8,510
Skilled nursing homes	7,037	16,049
Mental hospitals	(a)	13,975
Chronic-disease hospitals	(a)	6,357
Tuberculosis hospitals	(a)	229
Local health clinics	(a)	143
Noninstitutional:		
Physicians	193,360	4,879
Dental	51,319	2,767
Pharmaceutical	224,588	8,261
Special services	36,112	626
Home health care	1,644	127
Total	(b)	$92,846[c]

[a]Not available.

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

[c]Does not include about $16 million spent under Maryland's Medical Assistance Program for medical services to persons not meeting the Federal eligibility requirements for Medicaid.

Administration of the Maryland Medicaid program

Various organizational components of the State Department of Health and Mental Hygiene are involved in activities related to the Medicaid program.

The Medical Care Programs Administration is the State agency responsible for the administration and the operation of the Medicaid program, including utilization review activities.

Separate units within the Medical Care Programs Administration administer the programs of health services

provided under the State's Medicaid program. These units are responsible for directing and operating their individual program areas--physician services, hospital services, nursing-home services, dental services, pharmaceutical services, and special services--including utilization review.

The Purchased Care Services Division processes provider claims for payment for services rendered to Medicaid recipients. The Data Processing Division provides the computer services used in claims processing and in utilization review.

CHAPTER 2

MARYLAND'S MEDICAID UTILIZATION REVIEW SYSTEM

Utilization review activities began in April 1968 and have developed into the current utilization review system.

There is no written utilization review plan prescribing (1) how utilization reviews are to be made, (2) the services to be reviewed, (3) the criteria to be used in identifying questionable or deviant cases or patterns of care, and (4) the actions to be taken to correct inappropriate care or overuse of the Medicaid program. However, with respect to institutional services, some rather strict utilization review requirements are being used.

Although the Medical Care Programs Administration is responsible for Medicaid utilization review activities, it has not developed a coordinated, overall system for utilization review. No separate organization within the Administration is responsible for utilization review. Instead, utilization review activities are fragmented among the separate program sections that are responsible for administering the different medical services provided under the program.

Utilization review activities under Maryland's Medicaid program are performed by

--the Purchased Care Services Division, which processes provider claims for payment;

--the Baltimore City Health Department, which primarily reviews claims for physician services in Baltimore City;

--county health departments, which preauthorize services (approve prior to providing service);

--utilization review committees operating at individual medical institutions, which review patient cases; and

--the individual program sections of the Medical Care Programs Administration responsible for the different

medical services provided under the Medicaid program.

Utilization review consists of various procedures and controls which are designed to (1) evaluate and control the use of medical care and services and (2) provide for the processing of provider claims for payment for services.

The Medical Care Programs Administration has not provided for the systematic accumulation of data showing the claims reviewed and approved or disapproved and the amounts of reductions in claims. The availability of such data would enable management officials to (1) identify the providers who repeatedly file unreasonable claims and the recipients who repeatedly overuse the program so that their participation in the program may be restrained or stopped, (2) analyze overutilization of medical services to identify general trends and develop methods of avoiding such overutilization, and (3) make cost-benefit analyses of review activities.

The review activities being performed include specific controls applicable to institutional and noninstitutional services (see chs. 3 and 4) and general controls applicable to all services which are discussed in the following sections.

GENERAL CONTROLS APPLICABLE TO ALL SERVICES

Maryland's system for processing provider claims includes procedures for (1) insuring that recipients and providers of medical services are eligible to participate in the program, (2) checking the propriety of provider claims, and (3) insuring that fee payments are limited to the amounts established by the State.

Controls relating to eligibility

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

Providers' participation in the program is voluntary. To be eligible to serve Medicaid patients and bill the State for his services, a provider must (1) be licensed, (2) make application to participate in the program, and (3) obtain from the State a Medicaid provider identification number, evidencing the State's determination of the provider's eligibility to participate in the Medicaid program.

The data processing division compares provider claims for payment for services to recipients with a master eligibility file of recipient identification numbers, to insure that claims are for recipients eligible to participate in the Medicaid program. Also, during claims processing, the provider identification numbers on the claims are matched with those of eligible providers. Only claims submitted by eligible providers are cleared for payment.

The Social Services Administration--part of the State Department of Employment and Social Services--validates eligibility for public assistance, including Medicaid benefits, by means of a quality control system. Under this system, the Social Services Administration periodically selects samples of public assistance and medically needy cases and reviews each case selected to evaluate the appropriateness of the eligibility determinations and/or the amount of the payments. Corrective action is taken in those cases in which ineligibility or erroneous payments are disclosed.

In a March 1972 report to the Congress,[1] we reported on our examination of the effectiveness of the quality control systems used in eight States including Maryland. In that report we pointed out that Maryland had reviewed, for the quarter October to December 1970, less than half of the 1,500 cases required to support a statistically sound conclusion. We reported also that the high rate of ineligibility for the cases reviewed--about 10 percent--showed the importance of completing reviews of all sample cases. HEW requires that corrective action be taken if the rate of ineligibility exceeds 3 percent.

---

[1] "Problems in Attaining Integrity in Welfare Programs" (B-164031(3), March 16, 1972).

In June 1972 HEW officials informed us that the quality control situation in Maryland had not changed appreciably. For the 6-month period ended December 1971, the State had reviewed only about 32 percent of its required sample. The ineligibility rate for the cases reviewed remained high at about 7 percent.

To the extent that medical services were furnished to ineligible persons, inappropriate use was made of the Medicaid program.

Controls relating to propriety of provider claims

The processing of provider claims involves both manual and computer operations. Claims clerks manually review claims to insure that they are for covered services and are complete and correct. Claims clerks also select claims involving potential abuse or overuse of the Medicaid program by providers and refer them to the Medical Care Programs Administration for review and resolution.

Each service authorized by the Maryland Medicaid program has been assigned a code number. Providers must show the code number(s) on their claims for payment. During claims processing, provider claims are reviewed to insure that the services being claimed for payment are only those authorized by the program.

Claims not questioned during the manual reviews are keypunched and converted to a tape which is run through a computer and matched against identification numbers for eligible providers and recipients to insure that claims for payment are from eligible providers of services to recipients who have been issued identification numbers. If no exceptions occur, the computer continues processing the claims and generates a payment voucher.

If the computer takes exception, an error bill is prepared and returned to the claims processing group for resolution. Errors identified during manual review and during computer verification which cannot be resolved are returned to the providers for correction.

The Data Processing Division provides data processing services to the Department of Health and Mental Hygiene. As part of its workload the division produces various Medicaid computer reports based on recipient, provider, and claims processing data. The Department of Health and Mental Hygiene, however, has not provided for the development of recipient and provider profiles (histories of services received and provided) and the measurement of these profiles against norms of performance to identify cases of possible overutilization.

The claims processing system does not include procedures for identifying or preventing duplicate payments.

Controls relating to fees

The Department of Health and Mental Hygiene has administratively established the allowable charges for the Medicaid program. Payment is limited to amounts that have been established for each medical service covered by the program. Payments for institutional care are based on reasonable costs. Payments for skilled nursing-home care are limited to $18 a day. Payments to physicians, dentists, opticians, and podiatrists are limited to amounts in established fee schedules. As provider claims are processed, they are compared with the allowable charges; the lesser of these amounts are authorized for payment.

EVALUATION OF GENERAL CONTROLS

The claims processing system includes controls to insure that payments are (1) for services rendered by eligible providers to eligible recipients, (2) for services of the kind authorized by the program, and (3) limited to amounts established by the State.

The claims processing system does not include procedures for identifying or preventing duplicate payments to providers of services.

CHAPTER 3

UTILIZATION REVIEW OF INSTITUTIONAL SERVICES

Of the $93 million paid by Maryland for Medicaid services in fiscal year 1971, about $76 million, or 82 percent, was for institutional services. About $31 million was paid for hospital inpatient care; $16 million for skilled nursing-home care; $9 million for hospital outpatient services; and $20 million for care in mental, chronic-disease, and tuberculosis hospitals. (See p. 11.)

UTILIZATION REVIEW BY HEALTH INSTITUTIONS

Hospitals and nursing homes participating in the Maryland Medicaid program must comply with the Medicare utilization review requirements for hospitals and extended-care facilities (nursing homes). Generally, these requirements provide that each institution develop a utilization review plan which must provide for (1) review of admissions, durations of stay, and professional services furnished and (2) review of each case of extended stay. Such reviews are to be made by a committee composed of at least two physicians.

Development of utilization review plans

Utilization review plans for hospitals and nursing homes must be submitted to the State for approval.

Our examination of the Maryland Department of Health and Mental Hygiene files for 29 hospitals and 23 nursing homes which we randomly selected from about 60 hospitals and about 110 nursing homes participating in the Medicaid program during fiscal year 1970 showed that utilization review plans were on file for all 29 hospitals and all 23 nursing homes.

Implementation of utilization review plans

The State periodically surveys hospitals and extended-care facilities participating in the Medicare program. In these surveys the State reviews implementation of utilization review plans and verifies that each institution's utilization review committee is operating in accordance with

its utilization review plan which must provide for the review of Medicaid patients.

Our examination of records concerning State surveys at 27 hospitals and 18 nursing homes which we randomly selected from those participating in both the Medicare and Medicaid programs showed that:

--23 of the 27 hospitals and 16 of the 18 nursing homes were complying with their utilization review plan requirements.

--The four hospitals and two nursing homes not complying with utilization review plan requirements were given 60 days by the State to comply.

--Resurveys of these institutions after expiration of the 60-day period showed that they were complying with their plans.

CONTROLS OVER HOSPITAL SERVICES

The Maryland Medicaid program provides inpatient hospital care for categorically needy persons for as long as care is required. Inpatient hospital care for medically needy persons, however, is limited to 21 days per admission. Patient care in institutions for mental disease and/or tuberculosis is restricted to persons 65 years of age or older who are patients in State-operated institutions. Outpatient hospital services--medical care in a clinic or dispensary of a hospital--are also provided to eligible recipients.

The Hospital Services Section of the Medical Care Programs Administration administers the program for inpatient hospital care and outpatient hospital services. Nine persons, including a medical consultant, are employed in the section.

In addition to the reviews of the care and treatment of hospital patients by review committees at individual hospitals, utilization review activities relating to inpatient hospital services include (1) the review of questionable provider claims for services identified during claims processing and (2) a requirement for preauthorization for extension of care.

Claims clerks manually screen all provider claims for payment for inpatient and outpatient hospital services. During the screening process, claims clerks identify questionable claims. Claims may be questioned for various reasons, including (1) incomplete documentation for the services being claimed and (2) claiming services not covered by the Medicaid program. Claims for inpatient care are also matched by medical diagnoses and length of stay with a listing of about 46 selected diagnoses and the average days of care established by the State for these diagnoses.

Questioned claims and those exceeding the average days of care for the same diagnosis are referred to the medical consultant for review and resolution. In evaluating the appropriateness of the claim, the medical consultant may obtain, in addition to the information included in the claim, additional information from the hospital and opinions from other doctors in the State Department of Health and Mental Hygiene. The medical consultant may approve, disapprove, or reduce the amount claimed. If the claim is partially or completely disallowed, the hospital is notified and a copy of the notification is sent to the hospital's utilization review committee.

The Hospital Services Section does not maintain records identifying the questionable claims that were reviewed or showing the disposition of such cases. Therefore statistics on the claims reviewed and approved or disapproved and on the amounts of reductions in the claims were not available.

Extensions of hospital care beyond 14 days for both categorically needy and medically needy persons must be preauthorized. Each extension of care is limited to a maximum of 14 days; however, only one 7-day extension may be approved for medically needy patients, but more than one 14-day extension may be approved for categorically needy patients. Requests for extension of care are submitted to the Medical Care Programs Administration by the hospitals.

CONTROLS OVER SKILLED NURSING-HOME SERVICES

Maryland's Medicaid program provides nursing-home care in skilled nursing homes and for Medicaid patients in Medicare's extended-care facilities. The Nursing Home Services

Section of the Medical Care Programs Administration administers the program of skilled nursing-home services under Medicaid.

In addition to the reviews of the care and treatment of skilled nursing-home patients by review committees at individual nursing homes, utilization review activities relating to skilled nursing-home services include (1) controls applied during claims processing, (2) a requirement for preauthorization for a patient's admission to a skilled nursing home and extensions of care beyond periods of care previously approved, and (3) annual onsite visits to nursing homes to evaluate patients' needs for skilled nursing-home services.

Under Medicaid payment procedures the State sends each nursing home a monthly "preinvoice" or listing of its patients. The listing shows patients' names, eligibility numbers, payment rates, days of care, and other pertinent data. The nursing home is required to make any changes necessary to correct the data shown on the listing. For example, changes would be necessary if patients died or new patients were admitted during the month. When completed, the preinvoice becomes the nursing home's invoice to the State for billing purposes.

Prior to payment, the State compares the information on the invoice with the latest information in each patient's file and the amounts billed are adjusted if the bill is not correct. For example, the State will not pay for care provided to a new patient unless it has received a properly completed application for skilled nursing-home care from the local health department. Also, information concerning a patient's death or discharge is compared with information on the nursing home's bill for care, and correction is made when appropriate.

Local health departments (counties and Baltimore City) are responsible for approving skilled nursing-home care. Approvals are based upon a physician's medical evaluation of a patient's need for such care. Up to 6 months of care may be authorized. Requests for extensions of care beyond the period initially approved must also be reviewed and approved by local health departments.

Section 1902(a)(26) of the Social Security Act, as amended, requires that State plans, effective July 1, 1969, provide for a regular program of medical review and evaluation of skilled nursing-home care. The Maryland State plan provides for such a program.

Each nursing home participating in the Medicaid program is visited annually. During these visits, Medicaid patients are visited and their medical records are reviewed. A medical evaluation form is completed, and the patient's continued need for skilled nursing-home care is determined.

During the period February 1970 through April 1971, medical reviews of 2,213 patients in facilities licensed as skilled nursing homes showed that 723, or about 33 percent, of the patients required less than skilled nursing-home care. County health departments are responsible for moving patients not in need of skilled nursing-home care to facilities providing the level of care required by the patients. Possible actions include moving a patient to an intermediate-care facility or removing a patient from institutional care. Medicaid payments continue, at the higher skilled nursing-home care rate, until the patient is moved to another level of care.

No followup is made by the Nursing Home Services Section to see that patients identified during the survey as not in need of skilled nursing-home care are moved to appropriate levels of care.

EVALUATION OF CONTROLS OVER INSTITUTIONAL SERVICES

Preauthorization requirements for admittance to skilled nursing homes and for extensions of hospital care and skilled nursing-home care provide a means to control the use of institutional services.

Medical reviews of skilled nursing-home care have been effective in identifying patients inappropriately placed for the level of care required; however, there was no followup to see that corrective action was taken.

The review of hospital cases exceeding the average days of care for the same diagnosis and the review of questionable hospital claims appear to provide an adequate basis for utilization control. However, the Hospital Services Section does not maintain records of these reviews. Therefore statistics on the claims approved or disapproved and on the amounts of reductions in the claims were not available.

CHAPTER 4

UTILIZATION REVIEW OF NONINSTITUTIONAL SERVICES

Of the $93 million spent by Maryland for Medicaid services in fiscal year 1971, about $17 million was for noninstitutional services. Payments for physician services and pharmaceutical services amounted to about $13 million, or 79 percent, of the amount spent for noninstitutional services. Dental care, special services, and home health care costing $4 million accounted for the remaining noninstitutional services. (See p. 11.)

CONTROLS OVER PHYSICIAN SERVICES

Utilization review of physician services is performed by the Baltimore City Health Department and the Physicians Services Section of the Medical Care Programs Administration.

Utilization review by Baltimore City Health Department

The State provides the department with monthly computer tapes of payments it made to Medicaid providers in Baltimore. Using data on these tapes, the department's data processing unit produces semiannual reports of all services rendered by each physician. These reports are examined by personnel of the department to identify those physicians whose practice patterns deviate significantly from the average.

A report identifying the physicians selected, together with detailed listings of invoices for each physician, is referred to a physician consultant for review and investigation to determine whether overutilization was involved.

We were informed that in most instances the cases involving possible overutilization are resolved by the physician consultant. If fraud is indicated or if identified overutilization cannot be resolved by the physician consultant, the cases are referred to the State Medical Care Programs Administration for corrective action.

A review of records made available to us by department officials and our discussions with these officials showed that only 23 cases had been referred to the State since Medicaid utilization review activities were initiated in 1968.

State officials advised us that they had reviewed each case referred and that appropriate actions had been taken. Such actions may include referral of cases involving suspected fraud to an investigative unit and referral of cases involving program abuse or high utilization to the Maryland State Medical Society for peer review.

Utilization review by the Physicians Services Section

Annually the data processing division prepares computer printouts for the Physicians Services Section which summarize individual physician's Medicaid practices (physician summary reports). These reports, prepared on a State-wide basis, show detailed information concerning a physician's home and office practice, including patients seen, amounts charged, drugs dispensed, the average cost per patient, and the average number of visits per patient.

Summary reports are also prepared for all physicians by county. The average cost per patient and the average number of visits per patient as shown on the county summary reports are doubled and used as criteria by personnel of the Physicians Services Section to screen and to identify individual physicians whose average cost per patient or average number of visits per patient exceed these criteria. Cases exceeding the criteria--annually about 200 of the 3,000 physicians participating in the Medicaid program--are listed for review and investigation to determine if overutilization exists.

On the basis of an analysis of the detailed information on the physician summary reports, those physicians whose practice patterns appear to be justified are removed from the list. Those physicians remaining on the list (approximately 100) are subject to additional review.

State officials informed us that, to the extent that time permitted, detailed information available from the physician summary reports, physician pharmacy activity

reports, and physicians' current billings was accumulated and analyzed. They were usually able to do this for only about half of those physicians identified for additional review. We were informed also that detailed analyses were also made for all physicians receiving annual Medicaid payments of $20,000 or more. (In fiscal year 1971 there were 26 such physicians.)

If these reviews indicate that there has been overutilization of the program, one of the following actions is taken.

--Discussions are held with the physician to obtain additional information concerning the justification for his claims and/or to correct his overuse of the program.

--Cases of suspected fraud are referred to an investigative unit.

--Cases involving questionable medical practice or quality of care are referred to the State Medical Society for peer review.

The above procedures for performing utilization review of physician services by the Physicians Services Section are as described to us by State officials. We were unable to evaluate the effectiveness of these procedures or to determine the extent of utilization review because no records are retained which would identify the physicians reviewed or which would show the actions that were taken with respect to such cases.

CONTROLS OVER PHARMACEUTICAL SERVICES

The Pharmacy Services Section of the Medical Care Programs Administration is responsible for all Medicaid drug-related program matters, including utilization review.

Pharmaceutical services under the program provide for the dispensing of drugs and limited medical supplies when prescribed by physicians, dentists, or podiatrists. Charges allowed under the program are limited to the wholesale cost of ingredients plus a pharmacist's fee.

Certain pharmaceutical services require preauthorization by county health departments before they can be included as a program service. The following are examples of pharmaceutical services requiring preauthorization.

--Prescriptions costing over $10.

--Antibiotics for periods exceeding 10 days.

--Drugs for treatment of tuberculosis.

--Oral vitamins for patients over 6 years of age.

--Medical supplies for Medicaid patients in nursing homes.

--Any medical supply item with a retail cost of more than $5.

Utilization review, other than preauthorization, is limited to (1) the verification on a sample basis of drug prices in claims for pharmacy services, as part of the claims processing system, and (2) the review of cases involving unusual or excessive billings which are identified during claims processing. We were informed that only about two cases were questioned each month during claims processing.

The Pharmacy Services Section does not maintain records which identify cases involving utilization review or which show the disposition of cases reviewed.

CONTROLS OVER DENTAL SERVICES

The Dental Services Section of the Medical Care Programs Administration is responsible for administering the Medicaid dental services program, including utilization review.

The Maryland Medicaid program provides a wide range of dental services. The program requires that some dental services be preauthorized before the dental work is performed. Of the 59 dental services, 16--including dentures and root canal therapy--require preauthorization.

Preauthorization requests are approved by local health offices or by the Dental Services Section. Dentures account for 42 percent of the total dental program expenditures.

In addition to preauthorization for the more expensive dental services, utilization review activities include surveys by the Dental Services Section of the dental providers receiving the highest program payments. These surveys, which are made annually, include visits to dentists' offices, observation of the staff and office procedures, and discussions with the dentists to determine quality of services provided.

CONTROLS OVER SPECIAL SERVICES

The Special Services Section of the Medical Care Programs Administration is responsible for Medicaid program matters relating to special services, including utilization review. Special services include vision care, ambulance and transportation, medical supplies, podiatry, and diagnostic services.

Utilization review consists primarily of preauthorization of certain special services before they can be included as a program service. The following are examples of special services requiring preauthorization.

--Vision care program--prescription sunglasses, tinted lenses, two pairs of glasses, and contact lenses. Preauthorization is handled by local health agencies.

--Podiatry services--any service not included in the State's podiatry fee schedule, continued podiatry care, and nursing-home visits. One podiatrist is assigned to a nursing home and only that podiatrist can visit Medicaid patients in that home. Visits are limited to the number authorized. Preauthorization is handled by the Special Services Section.

Except for preauthorization activities, utilization review is limited to the review of questionable invoices which are identified during claims processing.

EVALUATION OF CONTROLS OVER NONINSTITUTIONAL SERVICES

There is no written utilization review plan applicable to noninstitutional services. There is no ongoing program to regularly identify for review those providers or recipients who exceed the usual or average limits of service.

Utilization review activities are fragmented among the individual organizational sections responsible for administering the different programs of medical care. Except for physician services, utilization review consists primarily of preauthorization activities and the review of invoices questioned during claims processing.

Review of noninstitutional services is provider oriented. Deficiencies found and corrective actions taken generally relate to claims by providers, especially physicians. We believe that increased attention to program use by recipients is needed to identify and control recipients receiving too much care under the program. For example, usage standards or norms of service should be used to identify recipients who repeatedly overuse the program so that their participation may be restrained or stopped.

We believe also that the absence of recipient and provider histories indicates a need for improvement in the utilization review system. Development of individual provider and recipient profiles and their measurement against established standards or norms of service can be used to identify cases of possible overutilization for further evaluation.

Some procedures have been established to control the use of noninstitutional medical services. However, the effectiveness of these controls and procedures and the results of utilization review cannot be determined or evaluated because, for the most part, records are not maintained which show (1) the providers who are identified for review because of questionable claims for payment or apparent excessive use of medical services, (2) the review actions taken to identify incorrect claims or overuse of services, and (3) the corrective measures taken in cases involving incorrect claims or overutilization.

- - - -

Medical Care Programs Administration officials informed us that a written utilization review system was being developed. They stated that the system would include control over questioned cases and would provide information on the review actions taken and on case disposition.

In developing its utilization review system, the State should insure that provision is made for

--a program of utilization review for each noninstitutional service available under the program and

--the use of parameters or limits of service to assist in identifying for review the providers and the recipients who exceed the usual limits of service.

CHAPTER 5

ADEQUACY OF RESOURCES FOR UTILIZATION REVIEW

Medical Care Programs Administration personnel expressed the opinion that the State had the necessary computer capability and funds for developing a utilization review system. State officials believe that, under the current system, a lack of sufficient personnel for making utilization reviews is their biggest problem.

Currently, utilization review activities are fragmented among the various program sections of the Medical Care Programs Administration. Some of these sections are staffed by only one individual who is responsible for all aspects of a program of medical services which includes utilization review. As a result, utilization review activity in these sections is limited.

In its budget request for fiscal year 1973, the Administration requested seven additional positions (doctors, nurses, and clerical employees) to enlarge its utilization review activities. Administration officials informed us that this request was denied. We were informed that the Administration plans to again ask for additional positions as part of its fiscal year 1974 budget request.

The State hired a consulting firm to make a comprehensive management information systems requirements study applicable to the needs of the Department of Health and Mental Hygiene. When the study is completed, the State will study and evaluate the findings and recommendations including those dealing with utilization review. Implementation of the information system is scheduled to begin by the end of fiscal year 1973. It is planned that the utilization review system now being developed by the State will eventually be made part of the overall management information system.

The ability of the State to implement its utilization review system will depend upon the amount of funds made available by the State legislature to acquire the necessary resources.

CHAPTER 6

EXTENT OF ASSISTANCE GIVEN BY HEW

Utilization review activities under Maryland's Medicaid program began in 1968 and have developed into the current utilization review system. The development of the various utilization review activities appears to be primarily a result of the State's initiative rather than of specific assistance by HEW.

HEW regional officials advised us that they had been able to provide only limited guidance or assistance to the State in the development of its utilization review system. The Medical Services Administration in the Social and Rehabilitation Service's regional office in Philadelphia, Pennsylvania, is responsible for assisting five States and the District of Columbia in administering their Medicaid programs. At the time of our fieldwork in Maryland, the regional staff consisted of five professional employees. Because of the small size of the staff, the amount of assistance provided to develop the utilization review system in Maryland was necessarily limited.

On the basis of a State Medicaid plan compliance review in June 1971, HEW regional officials concluded that Maryland's utilization review activities were limited to institutional services. HEW recommended that Maryland develop a written utilization review plan, with State-wide application, including all items of medical care and services under its Medicaid program. As noted on page 30, Maryland is currently developing a more comprehensive utilization review system.

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

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

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

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

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

State officials believe the model system is good but too late. They stated that about 98 percent of what is advocated in the HEW system has already been considered in the management information system being developed for the State by a consulting firm.

We believe HEW's model system may offer Maryland opportunities for improving its utilization review system and should be studied thoroughly.

CHAPTER 7

CONCLUSIONS AND RECOMMENDATIONS

CONCLUSIONS

Maryland does not have a written utilization review plan prescribing (1) how utilization reviews are to be made, (2) the services to be reviewed, (3) the criteria to be used in identifying questionable or deviant cases or patterns of care, and (4) the actions to be taken to correct inappropriate care or overuse of the Medicaid program. However, with respect to institutional services, some rather strict utilization review requirements are being used.

No separate organization at the State level within the Medical Care Programs Administration is responsible for utilization review. Instead, utilization review activities are fragmented among the separate program sections within the Administration.

Maryland's utilization review system does not provide for the systematic accumulation of data showing the claims reviewed and approved or disapproved and the amounts of reductions in claims. The availability of such data would enable management officials to (1) identify the providers who repeatedly file unreasonable claims and the recipients who repeatedly overuse the program so that their participation in the program may be restrained or stopped, (2) analyze overutilization of medical services to identify general trends and develop methods of avoiding such overutilization, and (3) make cost-benefit analyses of review activities.

Maryland's system for processing claims for payment of services includes controls to insure that payments are (1) for services rendered by eligible providers to eligible recipients, (2) for services of the kind authorized by the program, and (3) limited to amounts established by the State.

The claims processing system does not include procedures for identifying or preventing duplicate payments.

Medical reviews of skilled nursing-home care have been effective in identifying patients inappropriately placed for the level of care required; however, there is no follow-up to see that corrective actions are taken.

Except for physician services, utilization review of noninstitutional services consists primarily of preauthorization activities and the review of invoices questioned during claims processing. There is no ongoing program to regularly identify for review those providers or recipients who exceed the usual or average limits of service.

Utilization review of noninstitutional services is generally provider oriented. Deficiencies found and corrective actions taken generally relate to claims by providers, especially physicians. We believe that increased attention to program use by recipients would provide a means of controlling the use of medical services and would enhance the benefits obtained from Medicaid utilization review.

We believe that provider and recipient profiles should be developed and measured against established norms of service to assist in identifying cases of possible overutilization.

The effectiveness of the procedures which have been established to control the use of noninstitutional services and the results of utilization review cannot be determined or evaluated because records are not maintained to show (1) the providers who are identified for review because of questionable claims for payment or apparent excessive use of medical services, (2) the review actions taken to identify incorrect claims or overuse of services, and (3) the corrective measures taken in cases involving incorrect claims or overutilization.

Medical Care Programs Administration personnel expressed the opinion that the State had the necessary computer capability and funds for developing a utilization review system. They stated that, under their current system, the lack of sufficient personnel for making utilization reviews was their biggest problem. In its budget request for fiscal year 1973, the Administration requested funds for seven additional positions (doctors, nurses, and clerical

employees) to enlarge its utilization review activities. This request was denied. The Administration plans to again ask for additional positions in its fiscal year 1974 budget request.

The development and operation of Maryland's utilization review system resulted from the State's initiative rather than from specific assistance by HEW. However, HEW provided substantive assistance to the State in October 1971 when it provided Maryland with the model Medicaid Management Information System.

At the conclusion of our fieldwork, Maryland was developing a written utilization review system which was to (1) include control over questioned cases and (2) provide information on the review actions taken and on case disposition. In developing its utilization review system, we believe that the State should insure that provision is made for

--a program of utilization review for each noninstitutional service available under the program and

--the use of parameters or limits of service to assist in identifying for review the providers and the recipients who exceed the usual limits of service.

We believe HEW's model system may offer Maryland opportunities for improving its utilization review system and should be studied thoroughly. State officials generally agreed with our observations concerning utilization review activities.

RECOMMENDATIONS TO THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE

We recommend that the Administrator of the Social and Rehabilitation Service be required to assist the State and to monitor State actions to:

--Develop an effective utilization review system.

--Make a thorough comparison of the HEW model system and the management information system being developed

for the State, including provisions for utilization review, to adopt the provisions which could best meet the needs of the State.

--Provide for the systematic accumulation of data required by management officials to efficiently administer utilization review activities.

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

July 2, 1971

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

My dear Mr. Staats:

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

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

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

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

1. Results being achieved under the utilization review systems.

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

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

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

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

Sincerely yours,

Wilbur D. Mills
Chairman

WDM/ff