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July 25, 1978

Honorable Edmund G. Brown Jr.
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Honorable James R. Mills
President pro Tempore, and to Members of the Senate

Honorable Leo T. McCarthy
Speaker, and to Members of the Assembly

The Commission has reviewed the April 1978 cooperative report by the Departments of Health and Benefit Payments entitled, "The Cost Watch Project." This report consists of findings and recommendations emanating from extensive audits of a sample of five community hospitals which demonstrated high reimbursement costs, low annual occupancy and a significant percent of revenue recovered from the Medi-Cal program. The project staff selected a sample of 50 facilities, reduced it to 20 by an indexing process (which is not described) and selected from them the five hospitals with the highest participation in Medi-Cal.

To permit in-depth analysis of assets, the audit process applied was three times more costly than routine audits.

The audited hospitals received $3 million in Medi-Cal funds--only 1/2 of 1% of the $775 million budget for Medi-Cal expenditures in community hospitals. Audit exceptions were $1.2+ million, or 37¢ on each dollar paid to these hospitals for the 1976 audit period.

This finding is ominous. Although the sampling technique is such that no extrapolation to all community hospitals is warranted, the character of the audit exceptions nonetheless confirms many of the Commission's observations and warnings in both its initial 1976 report and the supplemental Medi-Cal Report of September 1977. We are concerned that such audits were not made previously by the current and the past two administrations.

It is incredible that specific, clear criteria still do not exist to define legitimate reimbursible costs in a multi-billion dollar government program a dozen years after its inception.

This deficiency has cost, and is costing, the taxpayer hundreds of millions of dollars annually.

These audits cry loudly for an expanded effort to conduct extensive audits on a representative sample of participating hospitals, not only on a skewed sample.

It is clear to this Commission that an auditing authority independent of the Health and Welfare Agency should be directed to conduct immediately the expanded audits called for in our review. As in the departmental Cost Watch audit team, the audit staff of the independent auditor should possess fiscal, medical and hospital ancillary expertise.

Unless audits prove otherwise, it is reasonable to expect the loose administration of the Medi-Cal Program is resulting in 20 to 25 percent of charges being highly questionable if not actually improper. Within this component of the Medi-Cal Program--namely, payments to private community hospitals--such exceptions would amount to $155 million to $194 million. Since this component of the Medi-Cal Program amounts only to 25 percent of total program expenditures, the Commission's previous estimate of excess Medi-Cal expenditures amounting to $300 million to $450 million now appears to be conservative. If other Medi-Cal components are as poorly administered as the community hospitals--and our past studies indicate this is likely--then the Medi-Cal overpayments total as much as $772 million a year. That is about one-fifth of the $3.5 billion budget for Medi-Cal, the largest single program in state government.

The Commission's previous report and analysis is strongly substantiated by the Cost Watch Project. The Commission is frustrated at the slow rate of response to our previous findings and recommendations. The Commission pledges its full support to any reform which will eliminate from the Medi-Cal Program any provider whose documented behavior is exploitive or lacking in integrity.

Findings and recommendations which follow are direct quotes from the 'Cost Watch' Report. The comments are from the Commission, with direct quotations extracted verbatim from the Commission's January 1976 report entitled, "A Study of the Administration of State Health Programs."

COST WATCH FINDING (1)

> "THE REASONABLE COST CONCEPT OF REIMBURSEMENT HAS BEEN STRETCHED PAST THE INTERPRETIVE LIMITS TO THE POINT OF PROGRAM RUPTURE."

COST WATCH RECOMMENDATION

> "Define the term reasonable and other ambiguous program references. Substitute clear and concise guidelines as to what the program will and will not reimburse."

COMMISSION COMMENT: Cost Watch audits show claims for reimbursement under Medi-Cal for such items as yacht club fees, football tickets, luxury automobiles and overseas travel for executive and corporate entertainment (liquor, food, flowers.) After twelve years of operation, no guidelines exist to describe specifically legitimate items for reimbursement under Medi-Cal.

Commission Medi-Cal Supplemental Report, page 8: "Methods of reimbursement constitute a powerful tool for containing Medi-Cal costs. Every opportunity should be employed to reduce the program's vulnerability to fee-for-service reimbursements and payments to institutional providers for reasonable costs. Fee and reasonable cost reimbursements place no incentives on the providers to control their costs. By contrast, prospective rates, fixed budgets, capitation payments and audited composite rates all convey the concept of the providers sharing the risk of cost over-runs. They force utilization controls, and to seek ways of attaining greater operational efficiency."

Commission 1976 Report, page 158: "The principle of selection of providers should be applied to the Medi-Cal Program as is now done under Crippled Children Services. The installation of a Professional Standard Review Organization capacity in the Department of Health...would enable the Department to identify patterns of practice which are substandard and eliminate those providers from participation. The quality review process should deal with all types of providers, individual and institutional. Reimbursements from Medi-Cal should be conditioned on a satisfactory review record. Incompetence and exploitation must be added to fraud as grounds for removal from the program."

COST WATCH FINDING (2)

"PROVIDERS READILY CIRCUMVENT EXISTING STATE AND FEDERAL COST CONTAINMENT MEASURES."

"In the hospital setting, the facility can and does, as demonstrated by this project, unnecessarily admit many beneficiaries as inpatients which directly circumvents the Schedule of Maximum Allowances (SMA) system. The additional cost to the program on an inpatient basis is twice, three times and even significantly more for most identical services, when compared to the outpatient Schedule of Maximum Allowances."

COST WATCH RECOMMENDATION

"The Cost Watch field review approach should be contained and expanded as it functions as the most effective cost-containment measure to date and also provides immediate feedback regarding provider trends and practices."

COMMISSION COMMENT: The Commission agrees strongly with this recommendation and suggests that a scientifically valid sample of all hospital providers be selected for similar intensive audits.

Commission 1976 Report, page 124: "Fees are substandard for Medi-Cal providers of integrity and competence but they apparently are not considered substandard by that segment of provider community which has learned that a large volume more than compensates for substandard fees. Only a reliable study of patterns of provision of services by specific individual and institutional providers can identify the statistical extent of overprovision of care. If selected review of claims is an indication, the elimination of high volume, low quality, low integrity providers entirely from Medi-Cal

would be beneficial for all concerned. Patients would be spared the danger of being exposed to care they do not need. The savings incurred may be sufficient to raise fees to honest and disciplined providers and keep them from abandoning the Medi-Cal patients."

COST WATCH FINDING (3)

"CHAIN-OWNED HOSPITALS BILL THE PROGRAM FOR GROSSLY INFLATED COSTS AND COSTS NOT RELATED TO PATIENT CARE."

COST WATCH RECOMMENDATION

"Hospital Home Office costs charged to the program should be limited to those costs that are necessary, directly related to patient care, and represent expenses that are common to a hospital operation."

COMMISSION COMMENT: Loading off corporate expenses onto hospital costs for purposes of reimbursement by government-subsidized health programs is clearly in violation of legislative intent and must be viewed as a form of exploitation of the taxpayer. Any provider guilty of this practice should be eliminated from participation as providers in both the Medi-Cal and Medi-Care programs.

Commission 1976 Report, page 154: "The vast number of transactions involved, and the participation of so many different providers, limit the ability of the Department to audit providers adequately. A defective information system enables providers to abuse the program without detection. At present, audits are initiated in instances of suspected fraud and when gross mismanagement is suspected. The number of routine audits is not adequate. Fraud investigators are hampered by lack of information and staff.

Even when audits clearly call for legal action to recover overpayments, such action is not necessarily taken. Providers selected for review of questionable claims are permitted to continue to participate for long periods of time."

COST WATCH FINDING (4)

"THERE IS NO EFFECTIVE CONTROL OF COSTS FOR ANCILLARY SERVICES BILLED OR FEES CHARGED THE PROGRAM BY HOSPITAL CONTRACTORS."

"Since the provider is reimbursed based on the cost of merchandise and services purchased, the nature of those purchases has been historically accepted as legitimate operating expenses and payable by the program. However, a close examination of the services involved clearly reflects that many of those costs previously considered legitimate, represent outrageous profits to contracting vendors and in some cases to the hospital entity...

"This means that if $500,000 worth of radiology services are charged during a period, the radiologist receives a commission of $350,000 which immediately becomes the hospital cost...It is essential to recall that had the identical work been performed on an outpatient basis, the radiologist would have received only a fraction of the $350,000 cost... This particular method of contractors maximizing profits from government programs is prevalent and continues to escalate..."

COST WATCH RECOMMENDATION

"Inpatient ancillary charges to the program should be limited to a fixed rate formula or maximum allowance system. Parameters for professional and contractor fees should be established on a similar basis."

COMMISSION COMMENT: The provision of ancillary services such as laboratory, x-ray, and pharmacy, etc., increasingly appear to be a source of indefensible and deliberate escalation of the cost of hospitalization under government programs as well as private insurance. The Department of Health should develop treatment protocols for common diagnoses, which can serve as standards for ancillary services provided in connection with a hospital stay. Such standards could be reflected in the computer screens applied by fiscal intermediaries to validate ancillary charges and eliminate payments for such services when they cannot be justified upon professional review.

During work on the supplemental report, the Commission strongly suggested that all of the details for ancillary services provided in the hospital be reported to the fiscal intermediary, not simply summarizing charges by case or service. This suggestion was accepted and built into the Request for Proposal (RFP) for rebid in the Medical Intermediary Organization (MIO) contract.

COST WATCH FINDING (5)

"PROVIDERS SURVEYED ROUTINELY CLAIM COSTS THAT ARE EXAGGERATED, CLEARLY NONREIMBURSABLE, AND THAT HAVE BEEN PREVIOUSLY DISALLOWED BY AUDIT."

"There are absolutely no effective sanctions or penalties available to curtail those providers habitually claiming program reimbursement for clearly defined non-allowable costs."

"Year after year, State examiners eliminate these types of cost during audit. Year after year, providers continue to claim the same disallowed costs, without fear of penalty, since the auditor and the program are powerless to act, in the absence of fraud."

COST WATCH RECOMMENDATION

"Financial penalties and/or program decertification should be imposed on providers consistently abusing program principles, whether by intended action or from repeated negligence. As an inducement for providers to

accurately report to government agencies, the practice of providing free audits for error-free reporting should be implemented. Providers with significant reporting errors or disclosures or program abuse should be charged for the full cost of the examination. Final audit findings should be routinely given to the news media in the form of press releases as a deterrent to program abuse."

COMMISSION COMMENT: These observations are central to the lack of administrative control over Medi-Cal costs. There is simply no excuse for the Department to continue to deal with providers repeatedly found guilty of significant amounts of cost disallowments. They should be promptly and permanently decertified as eligible providers.

Commission 1976 Report, pages 126-127: "Fifty-five thousand providers are included and the fee transactions which occur are counted in the millions. The record of these transactions is in a paid claims computer tape developed by the fiscal intermediaries and made available as a raw data base to the Department of Health. These paid claims are only potentially linked to the central identification file of eligible recipients. This separation and disarticulation of two key data bases obstruct systematic analysis of patterns of utilization of services. Only a crude analysis is made of the cost of categories of services to categories of eligibility, but this so-called 'budget information system' is not adequate to discern patterns of provision of services to specific eligibles by specific providers. Meaningful control of information and management analyses are thereby frustrated. The impact of fee reimbursements on the patterns of provision of services is buried in the claims tape file, obstructing the Department from answering the following questions of crucial importance:

- The statistical pattern of participation of various private providers of care? (Totals are available, but the volume of participation by particular providers is unknown.)

- The geographical distribution of Medi-Cal providers especially those with high volumes of participation?

- Profiles of the pattern of provision of care, especially by high volume providers?

- Profiles of the provision of services to specific eligibles, especially those who use a high volume of service?

- Comparisons in the patterns of provision of services to the Medi-Cal population with those using private insurance plans?

- Comparisons, within Medi-Cal, of patterns of utilization of services by fee providers, by private institutional providers, by foundations for medical care, by county institutions, by university medical centers, and by prepaid health plans?

"In a massive tax-supported health program...it is deplorable that such basic information has not been developed. Without such analyses, everyone is kept in the dark in attempting to judge the performance of the program

and to get it under a semblance of fiscal and quality control. Until these analyses are accomplished, the varying impressions of Medi-Cal Program characteristics remain speculative."

COST WATCH FINDING (6)

"FRAGMENTATION OF PROGRAM MONITORING AND EVALUATION FUNCTIONS SERIOUSLY IMPAIRS PROGRAM INTEGRITY AND EFFICIENCY."

"It became increasingly clear that, because the various monitoring and evaluative State organizations, represented in the project were physically separated and without an effective communication system, many program areas in need of review went unchecked simply because one group thought it was the other's responsibility."

COST WATCH RECOMMENDATION

"The complete program monitoring and evaluation components should be reviewed to determine communication and training needs. Staff should be educated and exposed to activities closely related to or impacted by their action."

Commission 1976 Report, page 154: "The Investigations Unit, located in the Department of Health, is disconnected from audits--their reports do not necessarily trigger action by the Audits Unit, which is administratively located in the Department of Benefit Payments as is the Recovery Unit. The Recovery Unit handles third-party payments in instances where Medi-Cal recipients are eligible for insurance which overlaps their Medi-Cal coverage.

The separation of Audits, Fraud Investigations, and Quality Control into two departments is unwise. All of these functions belong together in Medi-Cal so that proper coordination can be accomplished."

Commission Medi-Cal Supplemental Report, pages 14-15: "Concern continues over the fragmentation of Medi-Cal Program controls. The Commission is encouraged that the Medi-Cal administrator agrees with the need to consolidate basic control functions within the Medi-Cal Division. As indicated in the supplemental recommendations in this report, the Commission urges that this reorganization be accomplished as soon as possible. Following are the control functions and where the authority over them currently lies--the Department of Benefit Payments (DBP), the Medi-Cal Intermediary Operation (MIO), the Medi-Cal Division (MD), or the Division of Administration (DA):

Medical policy standards and criteria (MIO)
Criteria and enforcement of quality standards (MIO)
Utilization review standards (MIO)
Treatment authorization review (MD)
On-site case review (MD)

Surveillance and utilization enforcement (DA)
Fiscal intermediary monitoring--on site (MD)
Prepayment audits/edits for medical procedures (MIO)
Claims adjudication (MIO)
Post-payment audits and analyses of statistical norms (Not Done)
Program audits and appeals (DBP)
Program investigation (DA)
Third party recovery (DBP)

Some of these control functions shifts are addressed in the Department's request for proposal for the new fiscal intermediary contract. These moves, together with other improvements either recommended or endorsed by the Commission..."

COST WATCH FINDING (7)

"PROGRAM MONITORING EFFORTS ARE SERIOUSLY BLOCKED BY PROHIBITED ACCESS TO ESSENTIAL DATA."

COST WATCH RECOMMENDATION

"Program monitors should be given improved access to special reports and information; i.e., Dunn and Bradstreet data, Security and Exchange Commission reports and other similar sources. Either income tax return information should be made available on a "need to know" basis, or income staff and other regulatory agency personnel should participate in medical provider audits, where warranted."

COMMISSION COMMENT: Any organization or entity doing legitimate business with the government should, by contract, be required to comply with the principle of full disclosure in the same manner as elected and appointed officials and those employed in government.

COST WATCH FINDING (8)

"STATE LICENSING AND PLANNING ACTIVITIES CONFLICT WITH PROGRAM REIMBURSEMENT PRINCIPLES."

"In a low occupancy-utilization facility, this situation actually forces providers to retain unnecessary staff and other resources, regardless of cost or efficiency considerations, solely to avoid citable licensing violations. The government staff, as well as providers, concerned with the reasonable cost of furnishing services involving licensing minimums, are lawfully prohibited from taking prudent and necessary action to reduce the necessary and unreasonable cost incurred under such conflicting policies."

COST WATCH RECOMMENDATION

"A process to reduce licensed beds to 'necessity' levels should be implemented. Realty, equipment and staffing standards and guidelines should be coordinated to guide the industry and program alike.

COMMISSION COMMENT: Gross inefficiency resulting in excessive costs should constitute, standing alone, grounds for removal of a hospital provider from the Medi-Cal Program.

COST WATCH FINDING (9)

"PRUDENT HOSPITAL MANAGEMENT IS FREQUENTLY ABSENT IN FACILITIES WITH HIGH GOVERNMENT SPONSORSHIP, AS GOVERNMENT PROGRAMS PAY FOR THE MAJORITY OF POOR MANAGEMENT DECISIONS."

COST WATCH RECOMMENDATION

"Consideration should be given to limit Medi-Cal participation in hospitals to a maximum percent of patient case load, dependent on availability of other facilities and their services."

Commission Medi-Cal Supplemental Report, pages 9-10: "Currently, the Department is in the process of developing a "prudent buyer" project in which selection of hospital providers with lower rates and assured quality of care will be made. Services will be performed in selected hospitals which serve certain geographical areas in the state. This project awaits further development and approval of the U.S. Department of Health, Education and Welfare. It is based on the assumption that the state will save money by optimizing the occupancy of well-run hospitals and securing a higher level of quality of care."

COST WATCH FINDING (10)

"PROVIDERS READILY ABUSE THE THREE-DAY EMERGENCY PERIOD BY MISREPRESENTATION OF FACTS AND ADMISSIONS OF PATIENTS NOT MEDICALLY JUSTIFIED."

"Effectively, most emergency care reviews and approvals have been delegated to the Medi-Cal Intermediary Operations (MIO).

"The gist of the problem with this process is that the State and its surrogate (MIO) routinely pay for hidden and distorted provider charges for services that range from fabricated medical necessities to glorified baby-sitting services.

"The providers do not appear concerned about this type of abuse, but seem to promote such activities since they receive complete compensation from the government and simultaneously improve the facility occupancy and financial positions."

COST WATCH RECOMMENDATION

"The three-day emergency allowance should be reduced to a 24-hour observation period. The extension approval process should begin on the second day rather than the fourth day."

Commission 1976 Report, pages 120-121: "A selective review of paid claims raises a much larger question. Does the very comprehensive benefit structure induce over-provision of care by various providers, influenced by knowledge that payment is practically guaranteed? A recipient can, indeed, initiate more than one visit to a provider for the same problem, but the two-visit limitation has impeded him from doing so--rather, this visit limitation caused some people to stay away from providers even when they should be seen for fear of running out of stickers. The patient in the last analysis can only initiate a visit to the provider. From that point on, the utilization is under control of the provider who orders tests, administers treatment, performs surgery, etc. The extent of abuse of Medi-Cal by providers of marginal competence or integrity is not entirely known. The so-called "up front" controls of visit limitation, treatment authorization, etc., do not appear to have controlled excessive provision of services if growth of the budget is any indication. Post-facto controls of abuse in the claims review processing system by fiscal intermediaries are primitive and unimpressive. Paid claims information is largely in the control of the fiscal intermediaries whose proclivity to crack down on abusers is influenced by the fact that their governance is in the hands of providers who are not inclined to root out professionals who abuse the program or to develop detailed analyses of patterns of provision of services which might prove to be embarrassing."

COST WATCH FINDING (11)

"THE MEDI-CAL TREATMENT AUTHORIZATION (TAR) AND EXTENSION PROCESS IS SUBJECT TO SIGNIFICANT PROVIDER ABUSE AND PROGRAM ERROR."

"A very significant problem with the TAR process is that the authorization deals only with the medical diagnosis/procedure and length of stay. It does not control, authorize or evaluate related ancillary services. This creates a significant loophole in the system that results in a myriad of 'blue sky' billings to the program."

COST WATCH RECOMMENDATION

"Sanctions should be imposed on providers who, as a matter of routine or policy, regardless of medical necessity, perform unnecessary tests or treatments on beneficiaries only to minimize malpractice risks and improve the facility's occupancy position. Program practices should be closely examined and improved controls should be implemented."

COMMISSION COMMENT: See comment under FINDING (4)

COST WATCH FINDING (12)

"PROVIDER BILLINGS DO NOT CONTAIN ADEQUATE INFORMATION AND ARE FREQUENTLY MISLEADING. PROVIDER RECORDS AND DOCUMENTATION ARE OFTEN INCOMPLETE AND DO NOT SUPPORT THE MEDICAL SERVICES BILLED."

COST WATCH RECOMMENDATION

"The State should supplement or modify the existing treatment authorization and billing formats to include essential information on which accurate procedural, length of stay and ancillary approvals can be granted and paid. Routine hospital record compliance reviews should be performed to ensure documentation requirements are met. Existing sanctions should be applied in a timely and effective manner on providers not complying with legal requirements."

Commission 1976 Report, pages 152-153: "Medi-Cal is based on the presumption that health care will be provided in a timely fashion only when necessary and assure an appropriate treatment for a variety of problems in the most economical way possible. In order to discharge this responsibility, the Department requires timely and valid data on people eligible and on the health problems they develop which require treatment. In addition, the Department must develop normative criteria which describes legitimate intervention, the sequence of procedures used, and the appropriate patterns and setting for treatment, and the fair cost.

At present, the Department is dependent upon paid claims tapes furnished by fiscal intermediaries to perform program evaluation. But the Department is not now capable of applying tests of the claims payment process to validate the accuracy of coded claims, the basis for approving or denying claims on grounds of medical necessity, the reasonableness of charges, or the adequacy of the qualifications of the provider. For prepaid health plans, lack of data is even more critical since there exists, at present, no way of recording the procedural details of care provided.

Edits and audits being applied to paid claims are capable only of detection of gross errors in coding or illogical entries. The services utilization review process stimulated by recent federal requirements consists of a gross utilization edit which does not test the validity of services performed."

(See also Commission 1976 report, pages 120-121, quoted on page 10.)

COST WATCH FINDING (13)

"SIGNIFICANT COMMUNICATION PROBLEMS EXIST BETWEEN THE PROVIDER, MIO AND THE PROGRAM RESULTING IN PROGRAM OVERPAYMENTS."

COST WATCH RECOMMENDATION

"A centralized provider profile with regular input from all monitoring and evaluation functions should be created and maintained. Information should be stored with immediate access by automated data processing."

(See also Commission 1976 report, pages 120-121, quoted on page 10.)

COST WATCH FINDING (14)

"THE MEDI-CAL INTERMEDIARY OPERATION LACKS AN EFFECTIVE AUDIT PROCESS FOR CLAIMS REVIEW AND PAYMENT."

COST WATCH RECOMMENDATION

"The claims screening process performed by the Medi-Cal Intermediary Operation should be reviewed in depth. Procedural and staffing pattern changes should be made as necessary."

Commission 1976 Report, pages 158-161: "The Department should assume direct responsibility for the fiscal intermediary function. The Medi-Cal Management System should be reinstated as the first step toward the development of a standard review capability in the Department. To accomplish this capacity, the central eligibility file should be tied into the claims file, as discussed under Data Processing...

"The Department, in assuming fiscal intermediary operations, should plan to install a data system capable of performing analysis of characteristics or recipients as well as patterns of provision of services...Lack of control over information makes it literally impossible to control any program."

Commission Medi-Cal Supplemental Report, pages 13 and 14: "The Medi-Cal administrator has expressed agreement with the Commission on the importance of keeping open the eventual complete assumption of fiscal intermediary operations by the state. In fact, the proposal for a bid request for a new fiscal intermediary contract provides the state with an option to take over and operate the fiscal intermediary contract, if this is deemed desirable and cost effective.

"But in the interim, the department has taken perhaps the most significant step forward in the Medi-Cal Program in the past two years--implementation of the Medi-Cal Intermediary Operations (MIO) procurement project. This project was initiated, in part, because of criticisms made in the Commission's 1976 report. The Commission emphasized that successful management of the Medi-Cal Program requires control of basic policy decisions and those information systems which contain the basic details of the program.

"The MIO procurement staff, for the first time, gathered a complete description of the entire information system--the purpose of each component, its location and control, the types of data and reports produced and the uses to which information was put. They described the relationships which were intended among the information subsystems and the deficiencies which exist, primarily lack of departmental control over design, coordination and operation of information systems essential to program evaluation and management control. In addition, a review of the current MIO contract revealed that through the years the state simply had not monitored or audited the fiscal intermediary contract to protect against excessive profits."

COST WATCH FINDING (15)

"COSTLY PROGRAM INCONSISTENCIES EXIST IN THE MEDI-CAL FIELD SERVICES SECTION."

COST WATCH RECOMMENDATION

"Medical admission, procedure and length of stay authorization should be standardized in all Medi-Cal field services offices - statewide."

COST WATCH FINDING (16)

"CERTAIN MEDI-CAL POLICIES HAVE CREATED INDUSTRY 'NORMS' THAT HAVE RESULTED IN INFLATED COST AND CHARGES OF PROVIDER SERVICES."

COST WATCH RECOMMENDATION

"Medi-Cal reimbursement policies should be closely examined and those practices that are determined to be neither necessary nor appropriate, should be eliminated."

See Commission 1976 Report (pages 152-153) on page 11 for comment on FINDING (15) and (16).

COST WATCH FINDING (17)

"PROVIDER'S INTERNAL UTILIZATION REVIEW FUNCTION IS INEFFICIENT AND INEFFECTIVE."

COST WATCH RECOMMENDATION

"On-site workshops should be conducted on a regular basis to educate provider medical personnel with respect to program policies and procedures to ensure costs charged the program to U. R. activity represent productive and reliable efforts. The Federal mandate to implement Professional Standard Review Organizations as a substitute for existing front-end Medi-Cal controls should be carefully implemented and evaluated."

Commission 1976 Report, page 146: "No self-imposed controls of care in hospitals and nursing homes exist in fee practice."

NATHAN SHAPELL
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cc: Members, Commission on Government Reform