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REPORT TO THE CONGRESS



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Sizable Amounts Due The Government By Institutions That Terminated Their Participation In The Medicare Program

B-164031(4)

Social Security Administration
Department of Health, Education,
and Welfare

*BY THE COMPTROLLER GENERAL
OF THE UNITED STATES*

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AUG. 4, 1972



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

B-164031(4)

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

This is our report on sizable amounts due the Government by institutions that terminated their participation in the Medicare program. The program is administered by the Social Security Administration, Department of Health, Education, and Welfare.

Our review was made pursuant to the Budget and Accounting Act, 1921 (31 U.S.C. 53), and the Accounting and Auditing Act of 1950 (31 U.S.C. 67).

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

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

Comptroller General
of the United States

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ABBREVIATIONS

BCA Blue Cross Association

GAO General Accounting Office

HEW Department of Health, Education, and Welfare

SSA Social Security Administration

SRS Social and Rehabilitation Service

ECF Extended-care facility

Nevertheless, improvements in the techniques of intermediaries in estimating costs through closer adherence to SSA instructions could reduce overpayments. (See pp. 20 to 24.)

Overpayments occurred also because "current financing" Medicare payments--those made available to cover an institution's costs during the time it takes to process its bills and received payments--were not immediately refunded, though required. As a result, the institutions were paid again under normal billing procedures.

These overpayments could be minimized or avoided, if SSA informed the intermediaries more quickly than it has done of institutions that have terminated, or are terminating, their participation. (See pp. 25 to 27.)

Overpayments occurred also because tentative settlement payments--those based on the institutions' unaudited cost reports--proved to be excessive when intermediaries audited the cost reports. SSA amended its instructions in April 1971 to provide that tentative settlement payments to terminated institutions not be made on the basis of unaudited cost reports. (See pp. 28 and 29.)

Intermediary problems in identifying
and recovering overpayments

Once an overpayment to an institution has been identified, the intermediaries generally have two ways to effect recovery: to offset the overpayment against other Medicare amounts due or to obtain a refund.

GAO found that:

- In numerous situations four of the five intermediaries included in its review had not recovered known overpayments by the offset procedure.
- Intermediary collection efforts to obtain refunds had been only partially successful.
- 227 institutions were delinquent in submitting 332 cost reports covering interim payments of about \$17 million as of November 1970. Intermediaries were unable to determine the extent of any applicable overpayments. Submission of these cost reports had been due for an average of about 2 years.
- For two of the five intermediaries the amounts due the Government were not readily available from records maintained. (See pp. 31 to 40.)

Lack of adequate Federal controls

Responsibility is placed by law with the administrative agencies--such as SSA--for collecting debts determined to be due the United States which arise as a result of their activities. Debts which cannot be collected by the administrative agencies are to be referred to GAO for further collection action. (See p. 43.)

As of November 1971, SSA had not established accounting controls over the overpayments or delinquent cost reports for terminated institutions until after the cases had been referred to GAO for collection. Because these referrals represented only a small fraction of outstanding overpayments and delinquent cost reports, SSA did not have adequate controls to effectively manage collection of the vast majority of the outstanding debts. (See pp. 43 to 46.)

Terminated institutions indebted to Medicare
continued Medicaid participation

About 66 percent of the 136 institutions included in GAO's review that voluntarily terminated from Medicare continued participation in State Medicaid programs. Under Medicaid the Federal Government pays from 50 to 83 percent of the costs incurred by States in providing health services to individuals unable to pay.

As of November 1970 about 60 percent of the institutions continuing Medicaid participation had Medicare overpayments outstanding of about \$760,000 or had not submitted cost reports to account for Medicare payments of about \$1.3 million. These institutions had received payments under Medicaid which in some cases far exceeded the amounts they owed Medicare. However, under the existing law, the Federal share of Medicaid payments cannot be withheld from these debtor institutions. (See pp. 48 to 51.)

RECOMMENDATIONS OR SUGGESTIONS

HEW should obtain closer adherence by intermediaries to existing instructions and procedures and should improve procedures. (See pp. 30 and 41.)

To better manage its collection activities, HEW should establish management controls designed to provide current and meaningful information on the status of terminated institutions' Medicare accounts from the time they terminate their agreements until the accounts are paid or otherwise disposed of. (See p. 46.)

AGENCY ACTIONS AND UNRESOLVED ISSUES

HEW essentially agreed with GAO's recommendations. Of particular importance is developing a system requiring intermediaries to report quarterly to SSA on

- all outstanding overpayments to institutions, including those that have terminated, and
- the status of recovery actions by intermediaries.

The first quarterly report under this system is to include all overpayments outstanding as of June 30, 1972.

MATTERS FOR CONSIDERATION BY THE CONGRESS

The Medicaid law should be amended to authorize HEW to withhold--subject to appropriate advance notice to a State--Federal participation in State Medicaid payments to those institutions which have terminated from Medicare and which refuse to refund Medicare overpayments or to submit cost reports to account for Medicare payments received. (See p. 54.)

C₂ On March 20, 1972, the Senate Committee on Finance announced that, in connection with its deliberations on the Social Security Amendments of 1971 (H.R. 1), it had decided to initiate an amendment to the law along the lines recommended by GAO. (See pp. 29, 41, and 47.) As of June 1972 House bill 1 was being considered by the Finance Committee.

This report contains information on problems in recovering overpayments made to hundreds of terminated institutions. This information should assist committees of the Congress in carrying out their legislative and oversight responsibilities for the program.

CHAPTER 1

INTRODUCTION

Titles XVIII and XIX of the Social Security Act (42 U.S.C. 1395 and 1396), enacted on July 30, 1965, established the Medicare and Medicaid programs to help provide certain groups of eligible persons with protection against the costs of health-care services.

The Medicare program, which became effective on July 1, 1966, is administered by the Social Security Administration (SSA), Department of Health, Education, and Welfare (HEW), and provides two basic forms of protection against the costs of health care for eligible persons aged 65 and over.

--Hospital Insurance Benefits for the Aged (part A) covers inpatient hospital services and posthospital care in extended-care facilities (ECFs) and the patient's home. Part A is financed primarily by special social security taxes collected from employees, employers, and self-employed persons. About 21 million people have part A coverage.

--Supplementary Medical Insurance Benefits for the Aged (part B) is a voluntary program covering physician services and a number of other medical and health benefits. Part B is financed by premiums collected from each eligible beneficiary who elected to be covered by the program and by matching amounts appropriated from the general revenue of the Federal Government. About 20 million people have part B coverage.

In December 1971, about 6,750 hospitals and 4,100 ECFs were participating in Medicare.

The Medicaid program, which became effective on January 1, 1966, is administered at the Federal level by the Social and Rehabilitation Service (SRS) of HEW and is a grant-in-aid program under which the Federal Government shares in the costs incurred by the States in providing health-care services to individuals who are unable to pay for such care.

As of December 1971, 48 States and four jurisdictions--the District of Columbia, Guam, Puerto Rico, and the Virgin Islands--had adopted Medicaid programs. The Federal Government pays for 50 to 83 percent--depending on the per capita income of each State--of the costs incurred by the States under Medicaid. State Medicaid programs are required to provide inpatient and outpatient hospital services, laboratory and X-ray services, skilled-nursing-home services, physician services, home health services, and early and periodic screening and treatment of eligible persons. Additional services, such as prescribed drugs and dental care, may be included in its Medicaid program if a State so chooses.

TERMINATION OF AGREEMENTS
TO PARTICIPATE IN MEDICARE

As authorized by the Social Security Act, the Secretary of HEW made agreements with individuals or organizations for the participation of their institutions (hospitals and ECFs) in Medicare. The agreements require that the institutions meet and maintain certain legal and regulatory health and safety standards and obligate the institutions to comply with the reimbursement principles set forth by HEW.

Either party may terminate the agreement. The Secretary of HEW may terminate on notice to the institution and the public that the institution has not

- complied substantially with the agreement,
- met the required health and safety standards,
- provided information necessary to determine whether payments were due, or
- permitted examination of such records necessary to verify information provided to the Secretary.

An institution may voluntarily terminate the agreement at any time notice to the Secretary and to the public. The permanent or temporary cessation of the furnishing of services to a community, according to HEW regulations, is a voluntary termination of the agreement by the institution.

A common form of termination is a change of ownership. As defined by SSA, a change of ownership refers to a change of the individual or organization which had been a party to the agreement with the Secretary. A termination due to a change of ownership has usually resulted in the institution's continuing to participate in Medicare but participating under a new agreement. The new owner, however, may not be responsible for the debts incurred by the previous owner operating under the terminated agreement.

Number and types of terminations

The number of institutions that have terminated from Medicare has been substantial and has been continually increasing. Nationwide, as of December 1971, about 5,000 agreements involving hospitals and ECFs, or about 30 percent of the approximately 16,000 agreements entered into from Medicare's inception, had been terminated. ECFs accounted for 3,743, or about 75 percent of the terminations. According to SSA statistics, as of April 1970, December 1970, and December 1971, these agreements were terminated under the following circumstances.

Basis for terminating agreement to participate in Medicare	April 1970 (note a)			December 1970			December 1971		
	Total	Hospitals	ECFs	Total	Hospitals	ECFs	Total	Hospitals	ECFs
HEW initiated termination action	119	56	63	143	65	78	179	77	102
Institutions voluntarily requested termination	1,097	89	1,008	1,640	125	1,515	2,145	154	1,991
Institutions temporarily or permanently discontinued operating	421	305	116	622	432	190	744	495	249
Change of ownership--institution continued to participate under new ownership	1,104	317	787	1,473	445	1,028	1,819	517	1,302
Change of ownership--institution did not continue to participate	43	5	38	112	15	97	114	15	99
Total	<u>2,784</u>	<u>772</u>	<u>2,012</u>	<u>3,990</u>	<u>1,082</u>	<u>2,908</u>	<u>5,001</u>	<u>1,258</u>	<u>3,743</u>

^aWe used the number of terminated agreements as of April 30, 1970, as the basis for our review in three States. (See p. 12.)

FINANCIAL EFFECTS OF
TERMINATIONS UNDER MEDICARE

The Social Security Act requires that Medicare payments to institutions be made for the reasonable cost of services furnished to Medicare patients. It authorizes the Secretary of HEW to prescribe regulations establishing the methods to be used in determining reasonable costs and states that such regulations should provide for making suitable retroactive corrective adjustments where, for any accounting period, the aggregate reimbursement was either inadequate or excessive.

HEW issued regulations which established the guidelines and procedures to be used by institutions in determining reasonable cost. HEW intended that these reimbursement principles recognize all necessary and proper costs incurred by the institutions in furnishing services to Medicare patients and avoid including the costs of providing care to non-Medicare patients.

Payments to hospitals and ECFs under Medicare are usually made by fiscal intermediaries under HEW contracts administered by SSA.

The institutions are paid on a basis of estimated costs during the year. These interim payments are intended to approximate, as nearly as possible, actual costs to minimize the amount of retroactive adjustments when settlements are made with the institution after the end of each accounting period. To facilitate making settlements, SSA instructions require the institutions to submit Medicare cost reports to intermediaries generally covering 12-month periods of operation. Cost reports are to be submitted to the intermediary within 90 days after the end of the institution's reporting period.¹

¹In August 1970 SSA extended the due dates for submitting cost reports to 120 days after the close of the hospitals' reporting periods for those hospitals that elected to submit Medicare cost reports which had been certified as accurate by the hospitals' independent auditors.

In May 1972 SSA cleared for publication in the Federal Register a regulation which would require those terminated institutions (including those which have had changes of ownership) to file their Medicare cost reports within 45 days after the effective date of the termination.

Because the actual allowable costs are not determinable until sometime after the services are rendered, the interim payments made to an institution during its participation will generally require adjustment, which, in the case of institutions that have withdrawn or have changed ownership, are made after termination.

In those cases where cost reports filed by terminated institutions show that actual costs were higher than the interim payments received, the additional amounts due the institution must be paid. In situations where terminated institutions have been overpaid, they are required to refund such amounts to the intermediaries. However, SSA and its intermediaries have experienced difficulties in collecting amounts due.

EFFECTS OF TERMINATIONS UNDER MEDICARE ON CONTINUED PARTICIPATION IN MEDICAID

When an agreement to participate in Medicare is terminated, it does not necessarily mean that the institution can no longer participate in Medicaid.

HEW regulations require that a hospital be qualified to participate in Medicare to participate in Medicaid. If a hospital is involuntarily terminated from Medicare because it no longer meets that program's standards, it is also precluded from participating in Medicaid. On the other hand, those hospitals which voluntarily withdraw from Medicare are reexamined by the States to determine whether each hospital is still qualified for Medicare in order that it may continue to participate in Medicaid.

Under the Medicaid program a skilled nursing home must meet that program's standards to participate, which are similar to the standards for ECFs under Medicare. If an institution also participated in Medicare as an ECF, its termination from Medicare does not automatically result in its termination from Medicaid. In such cases, however, the State must report to SRS on the State's decision as to the institution's continued eligibility to participate in Medicaid as a skilled nursing home.

SCOPE OF REVIEW

We focused on five intermediaries (three Blue Cross plans operating under subcontracts with the Blue Cross Association (BCA) and two commercial insurance companies) which in three States (California, Massachusetts, and Texas) had served about 700 institutions (about 230 hospitals and about 470 ECFs) that had terminated from Medicare from its inception to April 1970. These 700 terminations represented about 25 percent of the terminations in the country at that time. Our principal objectives were to find out (1) why many of these institutions had voluntarily terminated from Medicare and (2) whether the federally prescribed systems and procedures were adequate to insure that terminated institutions were properly fulfilling their financial responsibilities under the program.

We mailed questionnaires to, or personally interviewed, officials of 226 institutions (86 hospitals and 140 ECFs) that had voluntarily terminated or had temporarily or permanently discontinued operating, to obtain information as to their reasons for doing so.

For each of the 700 institutions that had terminated as of April 1970, we reviewed the intermediaries' financial records and if submitted to the intermediaries, the institutions' Medicare cost reports, to determine the status of each institution's account at the time of its termination and as of November 1970.

We also examined pertinent records of the five intermediaries to determine the extent that overpayments and delinquent cost reports on terminated institutions had been sent to SSA for referral to us for collection as of February 1971.

Further, we examined the records at SSA Headquarters to find out how many of the cases submitted by the intermediaries as of February 1971 had been referred to us by November 1971 and ascertained their status.

For those overpaid institutions that had voluntarily withdrawn from Medicare as of April 1970, we examined the State Medicaid records to find out (1) whether these institutions had continued under Medicaid and (2) the amounts of

the Medicaid payments made after their withdrawal from Medicare.

We also examined the effectiveness of SSA accounting controls over overpayments to terminated institutions from the time of their terminations to the time their liability to Medicare, if any, was satisfied.

Our review was made (1) at SSA Headquarters in Baltimore, Md., (2) at three of the 10 SSA Medicare regional offices-- San Francisco, Calif., Boston, Mass., and Dallas, Tex.--(3) at the intermediaries' offices in Los Angeles, Calif.; Hartford, Conn.; Boston; Omaha, Neb.; and Dallas, and (4) at the State Medicaid agencies or their fiscal agents in Los Angeles and Oakland, Calif.; Boston; and Austin and Dallas, Tex.

We examined the basic legislation authorizing Medicare and Medicaid and the pertinent HEW regulations and SSA and SRS instructions implementing these programs.

CHAPTER 2

REASONS WHY INSTITUTIONS WITHDREW FROM MEDICARE

The 706 terminated institutions included in our review withdrew from the Medicare program for the reasons set forth below.

<u>Reason</u>	<u>Total</u>	<u>Hos- pitals</u>	<u>ECFs</u>
HEW initiated termination action	41	22	19
Institutions voluntarily requested termination	136	22	114
Institutions temporarily or permanently discontinued operating	90	64	26
Changes of ownership of institution-- institution continued to participate under new ownership	413	121	292
Changes of ownership of institution-- institution did not continue to participate	<u>26</u>	<u>2</u>	<u>24</u>
Total	<u>706</u>	<u>231</u>	<u>475</u>

About 66 percent of the 136 institutions voluntarily withdrawing from Medicare did not simultaneously withdraw from Medicaid.

Because the continuing withdrawal of health-care institutions from Medicare--particularly in rural areas--could tend to defeat one of the program's purposes of providing access to needed health care for the Nation's elderly, we contacted the 226 institutions (86 hospitals and 140 ECFs) cited above, which had either voluntarily withdrawn from the program or had discontinued operating, to obtain information on their reasons for doing so. Responses by 117 institutions generally cited one or more reasons for their decisions to discontinue operating or to withdraw. The most frequent reasons given were:

BEST DOCUMENT AVAILABLE

<u>Reason</u>	<u>Number of responding institutions</u>	<u>Percent of 117 responding institutions</u>
1. Problems with reimbursement and audit policies and procedures which resulted in disallowing certain costs.	49	42
2. Recordkeeping and cost-reporting problems and the lack of full reimbursement by the program for such administrative costs.	36	31
3. Problems with the intermediaries' retroactive denial of claims of Medicare patients after their admissions to the institution. ¹	27	23
4. Admission of too few Medicare patients.	25	21
5. Difficulties in keeping the required number of registered or licensed practical nurses.	23	20
6. The physical condition of the institution did not meet Medicare standards, and the costs to meet such standards were considered prohibitive.	13	11
7. ECFs associated with hospitals were discontinued because Medicare-reserved ECF beds were needed as regular hospital beds.	13	11
8. Inspection problems, particularly the amount of the institutions' personnel time required to work with the inspectors.	12	10
9. Excessive cost of retaining consultants (required by Medicare) who, according to the respondents, did not contribute to the level of patient care (e.g., medical records librarian, pharmacist, pathologist, dietician, etc.).	8	7

¹The problems associated with the retroactive denial of the claims when an intermediary concludes that the types of care furnished to a Medicare patient by a hospital or an ECF are not covered by the program (e.g., custodial-type care) are discussed in detail in our report to the Congress on improved controls needed over extent of care provided by hospitals and other facilities to Medicare patients (B-164031(4), July 30, 1971).

As shown by the above responses, most of the reasons for withdrawing related to reimbursement and audit policies and Medicare recordkeeping requirements.

The intermediaries included in our review submitted their written comments on a draft of this report to SSA. One intermediary, which served principally ECFs, said that ECF disenchantment with Medicare had resulted:

- From the program's recordkeeping and accounting demands.
- From the fact that many nursing homes found it more profitable to serve domiciliary and long-term care patients rather than those needing skilled ECF services.
- From the continual tightening of SSA guidelines as to what constituted skilled ECF care resulting in retroactive denials of claims for which ECFs had not been reimbursed for the costs of services provided in good faith.

BCA, in commenting on behalf of the three Blue Cross intermediaries, stated that, because the 117 responding institutions generally cited more than one reason for withdrawing from Medicare, it would not necessarily follow that problems with reimbursement and audit policies and recordkeeping requirements were the principal reasons for their withdrawals. BCA pointed out that, if an institution had advised us that the physical condition of its facility did not meet Medicare standards and that problems with reimbursement policies were two reasons for its withdrawal, the physical condition of its facility may have necessitated its withdrawal, regardless of the other reason.

It seems to us, however, that if an institution is not satisfied with Medicare reimbursement policies, it would be more likely to withdraw from the program rather than to spend the money to bring its facility up to Medicare standards.

CONGRESSIONAL DELIBERATIONS AND HEW ACTIONS
AIMED AT ALLEVIATING CAUSES FOR WITHDRAWALS

From 1970 to 1972 the Congress has been considering various amendments to the Medicare and Medicaid laws aimed at improving the programs' operating effectiveness, including certain changes which could alleviate some of the reasons for hospitals' and ECFs' withdrawing from Medicare.

These legislative proposals were included in either or both the House or Senate versions of the Social Security Amendments of 1970 (H.R. 17550). House bill 17550 was passed by the House of Representatives on May 21, 1970. The Senate passed an amended version of House bill 17550 on December 29, 1970, but the bill was not enacted into law because the Ninety-first Congress adjourned before the differences in the bills could be resolved by a House and Senate conference committee.

Most of these legislative proposals were also included in the Social Security Amendments of 1971 (H.R. 1) which was passed by the House of Representatives on June 22, 1971. As of June 1972, House bill 1 was being considered by the Senate Committee on Finance. In March 1972 the Committee added various provisions to House bill 1 which had been included in the Senate version of House bill 17550 but which had not been included in the House version of House bill 1.

The proposed legislative changes--as well as other legislation and related actions initiated by HEW--are summarized and are keyed to the reason cited by the institutions for withdrawing from Medicare, as follows:

Problems with Medicare reimbursement
policies, including intermediary
disallowances of costs (reason 1)

Under the existing Medicare law, institutions have no right to appeal intermediary determinations on the allowability of costs. The proposed legislation would provide for a reimbursement appeal board to be established to hear institutions' appeals on reimbursement decisions made by intermediaries where the amount at issue is \$10,000 or more.

Problems with Medicare recordkeeping and cost-reporting requirements (reason 2)

Another legislative proposal would simplify ECF reimbursement and cost-reporting requirements. Under this proposed change, HEW could adopt as reasonable cost payments for ECFs under Medicare in any State the payment rates developed in that State under Medicaid for comparable facilities if HEW finds that such Medicaid payment rates--which are generally established before providing the services--are reasonably related to costs.

Further a report of the Senate Finance Committee¹ pointed out that the Committee and HEW had agreed that for the smaller institutions (e.g., those having fewer than 100 beds), Medicare should simplify its cost-reporting requirements. In May 1972 HEW published revisions to the Medicare reimbursement regulations aimed at accomplishing this.

Problems with retroactive denial of claims (reason 3)

To deal with the problem of the retroactive denials of ECF claims by intermediaries and SSA, the legislative proposals include a provision which would authorize HEW to establish certain limited periods when the ECF care provided to Medicare patients would be presumed to be covered by the program and payment for ECF services provided during these periods would be guaranteed. In June 1971 HEW issued final regulations authorizing an "assurance of payment" procedure under which ECF care would be presumed to be covered by Medicare for a reasonable time while the intermediary reviewed pertinent medical information and made a coverage determination.

Problems in keeping the required number of registered nurses (reason 5)

In January 1971 the law was amended to permit HEW to waive the requirement that hospitals, to be eligible to

¹S. Rept. 91-1431 to accompany H.R. 17550, the Social Security Amendments of 1970.

participate in Medicare, must provide 24-hour nursing service rendered or supervised by a registered nurse. The waiver authority is limited to any 1-year period until January 1976 and is applicable to hospitals in rural areas where the inability of the institution to qualify as a hospital under Medicare would seriously reduce the availability of hospital services to individuals in the area.

In addition, a legislative proposal would require the Secretary of HEW to develop and use proficiency examinations to determine whether health care personnel, such as nurses, not otherwise meeting specific formal criteria now included in the Medicare regulations, have sufficient training, experience, and professional competence to be considered qualified personnel for purposes of determining an institution's eligibility to participate in Medicare.

Excessive costs of retaining consultants
to qualify for participation in Medicare
(reason 9)

To alleviate the problem of retaining consultants, a legislative proposal would authorize State agencies (e.g., health departments) to provide the required consultative services to those ECFs that request them in such specialty areas as maintaining medical records and formulating policies governing dietary and social services. Medicare payments would be made directly to the State agency for its cost of providing such consultative services and would thereby relieve the institution of such costs.

CONCLUSION

These actions being considered by the Congress and HEW should, if implemented, reduce many of the objections to Medicare which were raised by the institutions that we contacted.

CHAPTER 3

PROBLEMS RELATING TO MINIMIZING OVERPAYMENTS

MADE TO INSTITUTIONS TERMINATING FROM MEDICARE

Many institutions, when they terminated from Medicare, owed the program amounts totaling millions of dollars. Five intermediaries in three States made overpayments of about \$8.1 million to 384 of the 700 institutions that had terminated their agreements from the program's inception in fiscal year 1967 through April 1970. As of November 1970, 76 hospitals and 194 ECFs in the three States still owed the program about \$1.5 million and \$3.1 million, respectively. The reasons for and the amounts of these overpayments, totaling \$4.6 million as of November 1970, were as follows:

	Amount (<u>millions</u>)
Interim payments made on an estimated-cost basis exceeded allowable costs as later claimed by the institutions or determined by intermediary audits.	\$3.6
Payments to institutions ("current financing" and "accelerated payments") to finance services provided during the time it takes the institution and the intermediary to process and pay bills were not refunded, though required, at termination.	.7
Tentative settlement payments made to institutions on the basis of unaudited cost reports proved to be too high when the cost reports were audited.	<u>.3</u>
Total	<u>\$4.6</u>

Our findings and comments on overpayments made to hospitals and ECFs which had terminated from Medicare and our views on ways to avoid or minimize such overpayments follow.

PAYMENTS BASED ON
ESTIMATED COSTS WERE TOO HIGH

The principal cause of overpayments has been the payment to institutions of amounts based on estimated costs

(interim payment rates) which were higher than the actual allowable costs of providing service. About 78 percent of the overpayments of \$4.6 million, or about \$3.6 million, which were outstanding in November 1970 occurred because the interim payments to the institutions were too high. These overpayments were made to 197, or about 28 percent, of the 700 institutions included in our review.

Under the present Medicare retrospective cost-reimbursement system, overpayments, as well as underpayments, to institutions cannot be completely avoided because an institution's actual allowable Medicare costs are not determined and settled until after the accounting period in which the services are provided; often the process takes as long as 2 or 3 years.¹ Under this system it is expected that adjustments will be made for the difference between the payments made on an estimated-cost basis during each accounting period and the actual allowable Medicare-related costs as determined later. We believe, however, that improvements in the intermediaries' techniques of estimating costs and making interim payments to institutions could result in reduced overpayments.

HEW requirements for determining
interim payment rates

HEW regulations and related instructions state that interim payment rates are to be established by the intermediary and should reflect, in general, the average cost of services provided based on the institution's cost experience, or if none is available, on costs of comparable institutions or budgeted or projected costs. In addition, intermediaries are required to periodically review the most current cost data and to adjust the interim payment rates.

¹On June 23, 1971, we issued a report to the Congress, entitled "Lengthy Delays in Settling the Cost of Health Services Furnished under Medicare" (B-164031(4)), in which we discussed the causes for the delays in every step of the settlement process from the preparation of the cost reports by institutions through the audits of the cost reports by intermediaries to the final settlement with the institutions concerning their actual and reasonable Medicare costs to be reimbursed under the program.

Requirements for determining and reviewing interim payment rates not followed

Four of the five intermediaries whose procedures we reviewed did not comply in many instances with the regulations in

- establishing the initial interim payment rates,
- periodically reviewing cost data to adjust such rates, or
- making adjustments when there was evidence available which indicated a significant difference between the established interim rates and the more current cost data.

The fifth intermediary generally followed HEW regulations in establishing and adjusting interim payment rates. This appeared to have minimized overpayments to the institutions which it served and which had terminated from Medicare. Of 41 terminated institutions for which cost reports had been audited by the intermediary for all the periods of participation, 35 had overpayments outstanding at termination.

For 30 of the 35 institutions, however, the cost reports for their last period of Medicare participation either showed no overpayments or showed that the overpayments were lower in relation to total Medicare-related costs than the overpayments for the earlier periods. This indicated to us that over a period of time, this intermediary's interim payment rates became closer to rates based on the institutions' actual costs.

Generally officials of the four intermediaries which had not complied with the regulations stated that, in the initial phase of Medicare, there was a lack of accurate cost and statistical data on which to establish interim payment rates. One intermediary usually set its initial interim rates at 90 percent of charges for hospitals and 95 percent

of charges for ECFs.¹ It had not requested cost data for setting initial interim rates nor for followup adjustments.

Officials of another intermediary said that its generally applied interim payment rate of 100 percent of charges¹ had been based on a survey of institutions' costs and charges made by its audit subcontractor before the program started. However, periodic followup reviews were not made because of a shortage of staff.

A third intermediary based its initial interim rates on institution-furnished cost data but made no periodic followups to obtain current cost data. It explained that it was unable to do so because of shortage of staff.

The fourth intermediary established initial interim payment rates on institution-furnished cost data and, for new facilities which had little or no prior experience, on the experience of similar facilities in the area. Although the required periodic followup review of cost data was not strictly adhered to, an intermediary representative told us that reviews were made 4 or 5 months after the initial rates had been established. However, we found no documented evidence of such reviews or of any adjustments to the rates resulting from such reviews.

In addition, these four intermediaries generally were not adjusting rates when more current cost data became available upon submission of the institutions' Medicare cost reports.

For example, in February 1968 one intermediary reviewed an institution's cost report for the period ended December 31, 1966. The report showed that the institution had been overpaid \$20,000 for the period. The institution's interim payment rate of 85 percent of charges was not adjusted even though the cost report showed that the interim

¹In September 1971 HEW issued instructions to Medicare intermediaries to discontinue before December 1, 1971, the practice of basing interim payment rates for ECFs on a percentage of charges. Interim payment rates for ECFs are now required to be based on cost experience of the institution.

rate should have been about 81 percent of charges. The institution, owing the program about \$250,000, terminated its Medicare agreement in March 1969. If the intermediary had adjusted the institution's interim payment rate in February 1968, when there was evidence that the rate was too high, about \$53,500 of the \$250,000 overpayment to this institution could have been avoided.

An HEW audit agency report on this intermediary covering the period March 1967 through April 1969 commented on the intermediary's failure to make timely adjustments to interim payment rates for institutions when more current cost data showed that the rates were too high. In its reply to the HEW audit findings, the intermediary stated that effective September 1969 a program had been initiated to review the Medicare interim payment rates for all institutions.

Our review revealed, however, that after September 1969 the intermediary had not adjusted interim payment rates when data in the Medicare cost reports indicated that such rates were incorrect. As of November 1970 this intermediary had outstanding overpayments to 58 terminated institutions of about \$1.4 million which were due to excessive interim payments. A further review by us, however, showed that in December 1970 the intermediary was adjusting interim payment rates when available cost data indicated that the rates were too high or too low.

CURRENT-FINANCING PAYMENTS NOT REFUNDED

HEW regulations require that payments be current so that institutions will not be disadvantaged by having to put up their own money for purchasing goods and services well before they are paid by Medicare. Therefore, in addition to the basic procedure for paying the institution on an estimated-cost basis upon the submission of bills, Medicare financing is available to cover the cost of services provided during the time it takes the institution to prepare the bills and the intermediary to process and pay them.

One type of such financing, referred to as current financing, reimburses the institution for services provided to Medicare patients during the average time it takes to prepare, process, and pay a bill. The amount of current financing to an institution is limited to an average of the recent monthly interim payments to the institution. This financing is immediately refundable to the program if the institution terminates its participation.

Another type of financing, referred to as accelerated payments, is available to an institution when unusual payment delays are experienced beyond the normal billing cycle and the institutions can demonstrate a need for such additional financing. These are temporary-financing payments which are refundable to the program within 90 days.

Because these types of financing are applicable to services to be eventually billed and paid for through the normal interim payment procedures, an overpayment to an institution occurs if at termination, these amounts are not promptly refunded, though required, and the institution again receives payment for the applicable services through continuing interim payments.

When the 700 institutions included in our review terminated from Medicare, about 320 institutions owed the intermediaries about \$3.3 million in current financing and about \$130,000 in accelerated payments which should have been refunded immediately to the intermediary. As of November 1970, 98 institutions owed current-financing and accelerated payments amounting to about \$733,000 and \$3,000, respectively.

As discussed in chapter 4, we found numerous situations where even when the intermediaries were aware of an institution's termination, they had not taken full advantage of the opportunity to offset some of these outstanding balances against other payments due the institution. We believe that notwithstanding the past lack of intermediary initiative in this area, it would help to minimize overpayments resulting from unrefunded current-financing payments if more timely information were made available to the intermediaries by SSA concerning institutions that have terminated or intend to terminate from Medicare. According to SSA instructions dealing with terminations, institutions are required to notify SSA which, in turn, is required to notify the applicable intermediary.

Information for three intermediaries showed that an average of between 23 and 60 days elapsed after the effective date of an institution's termination from the program before the intermediary was notified by SSA of that action. As the time between termination dates and notification increases, any possibility of offset by the intermediary of outstanding current financing against other amounts which may be due an institution becomes more difficult because the institution has already been paid for the services during the normal billing cycle.

SSA was not always promptly notifying the intermediary when it became aware of an institution's termination although SSA was aware of such action at or near the termination dates.

For one intermediary we found that about 36 days elapsed between the time that SSA became aware of an institution's termination and the time that the intermediary's payment department learned of the termination. An SSA regional official pointed out that on the basis of his sample of terminations, it took an average of 18 days for SSA to notify the intermediary. Information in the intermediary's files on the same sample showed that it took 31 days. It appears, however, that there was an additional timelag from the date of receipt by the intermediary until the notification filtered to the department which had the responsibility for processing bills and making payments. In May 1971 officials of this SSA regional office established firm procedures

to insure more timely and positive notifications of terminations to this intermediary; however, the condition revealed by our review may exist at other SSA Medicare regional offices.

We believe that current-financing overpayments could be reduced if the cognizant intermediaries' Medicare departments were promptly notified of institutions' terminations from Medicare, because the intermediaries would be in a better position to make offsets against interim payments due the institutions during their normal billing cycles immediately following terminations.

EXCESSIVE TENTATIVE SETTLEMENT PAYMENTS TO
INSTITUTIONS BEFORE FINAL SETTLEMENT

As another method of making Medicare cost reimbursements as current as possible, intermediaries are required to pay or collect, as appropriate, amounts shown to be due upon receipt and a preliminary or "desk" review of institutions' cost reports. These payments, which are subject to later audit, are called tentative settlements.

For 56 of the 700 institutions included in our review, the intermediaries made tentative settlement payments totaling \$711,000, of which \$392,000 was paid after the dates that the institutions had terminated. Although the tentative settlement payments were generally less than the amounts claimed, substantial overpayments did occur. The overpayments became evident as a result of the intermediaries' field audits. As of November 1970, 44 of the 56 institutions owed Medicare tentative settlement payments of about \$270,000 in excess of the amounts due them, of which about \$147,000 applicable to 26 institutions had resulted from payments made after termination.

The 44 institutions' cost reports, as filed, showed that the costs incurred were higher than the interim payments and that additional payments were due the institutions. Consistent with SSA instructions at the time, the intermediaries paid portions of the additional amounts claimed as tentative settlements. After the intermediaries had made detailed audits of the cost reports, they frequently found that the institutions had either (1) understated the interim payments they had received or had billed the intermediaries or (2) overstated the amounts of the allowable Medicare-related costs.

The 44 institutions were, therefore, overpaid on the basis of the interim payments and owed the program both the amounts of the excessive interim payments and the tentative settlement payments. For example:

--One institution submitted a cost report showing that \$51,292 was due from the program. On the basis of a desk review of the cost report, the intermediary made a tentative settlement payment to the institution of

\$12,823, or 25 percent of the claimed amount. The intermediary's subsequent audit of this cost report showed that the institution's prior claim was not correct and that it actually owed the program \$72,822, which, when added to the tentative settlement payment of \$12,823, had resulted in a total overpayment of \$85,645.

--An institution's cost report showed that it was due \$20,498; a tentative settlement payment was made to the institution of \$18,448. The field audit showed that the institution actually owed the program \$23,947, which, when added to the tentative settlement payment, had resulted in a total overpayment of \$42,395.

In April 1971 SSA amended its instructions to provide that tentative settlement payments not be made on the basis of unaudited cost reports from terminated institutions. If properly implemented by the intermediaries, this procedure should minimize future overpayments to institutions after termination.

CONCLUSIONS

Under the present Medicare reimbursement system, payments are made to participating institutions on an estimated-cost basis far in advance of the time that their actual allowable Medicare-related costs are determined. Under this system, overpayments, as well as underpayments, are bound to occur because precise cost determinations in advance are not expected of the intermediaries.

When an institution continues to participate in Medicare, overpayments can be adjusted at any time by offsetting them against more current interim payments to the institution. When an institution terminates, however, such a remedy may be available for only a relatively short period of time.

Therefore we believe that closer adherence to existing instructions and procedures, as well as improvement in such procedures, would help to avoid or minimize overpayments to terminated institutions.

RECOMMENDATIONS TO THE SECRETARY OF HEW

We recommend that HEW, through SSA:

- Emphasize the need for stricter compliance by intermediaries with the existing requirements, particularly in using current cost data, in determining and periodically reviewing institutions' interim payment rates.

- Improve its procedures by requiring its intermediaries to be notified promptly of institutions that intend to terminate or have terminated from Medicare to help minimize overpayments resulting from unrefunded current-financing payments.

HEW COMMENTS AND ACTIONS

In a letter to us dated May 22, 1972, HEW commented on a draft of this report. (See app. II.)

HEW agreed with our first recommendation and stated that to enable SSA to better monitor intermediaries' activities in determining and periodically reviewing institutions' interim payment rates, SSA had placed SSA resident representatives at the intermediaries' offices and had developed other surveillance programs to concentrate on and to correct conditions which tended to cause overpayments.

With regard to the second recommendation, HEW stated that existing SSA instructions to its Medicare regional offices provided for the intermediary to be notified when an institution voluntarily or involuntarily ended its participation. HEW added that SSA would advise all its regional offices of our findings and would remind them of the need to promptly notify the intermediaries whenever the regional offices learned that an institution had terminated, or intended to terminate, from Medicare.

CHAPTER 4

INTERMEDIARY PROBLEMS IN RECOVERING OVERPAYMENTS

Since Medicare's inception SSA has amended its instructions to intermediaries regarding the steps to follow in recovering overpayments to institutions. Once such an overpayment has been identified, the intermediaries generally have two ways to effect recovery:

- Offsetting the overpayment against other Medicare amounts due the institution.
- Obtaining a refund from the institution.

In the case of institutions that terminate from Medicare, promptly making offsets is particularly important because of the limited time that may be available after termination.

In numerous situations, four of the five intermediaries included in our review did not take advantage of their opportunities to offset known overpayments against interim payments and tentative settlement payments made to institutions both before and after termination. Further, after an opportunity for making offsets did not exist, the intermediaries' efforts to collect overpayments from the terminated institutions were not too successful.

In addition to having problems in recovering overpayments, the intermediaries have also experienced difficulties in determining the amounts of overpayments because as of November 1970, 227 of the 700 institutions included in our review, or about 30 percent, had not filed cost reports to account for interim payments of about \$17 million made on the basis of their estimated costs. Two of the five intermediaries had not established sufficient accounting controls to accurately determine how much an institution was indebted to Medicare.

SSA INSTRUCTIONS TO INTERMEDIARIES ON RECOVERING OVERPAYMENTS

During the first 4 years of the Medicare program, SSA issued only limited instructions to the intermediaries

pertaining to the procedures to follow in recovering overpayments to terminated institutions. Although certain SSA instructions issued in September 1967 did not specifically deal with the special problems associated with recovering overpayments from terminated institutions, these instructions did state that any overpayments shown by an institution's annual Medicare cost report was payable by the institution at the time the cost report was submitted to the intermediary. These instructions stated further that if a lump-sum payment was not practicable, the intermediary and the institution should arrange for recovering the overpayment by offsets against any future interim payments and that full recovery would be accomplished within 90 days after the filing of the cost report.

In September 1970¹ SSA issued new instructions to its intermediaries which state that when an overpayment is identified (1) the intermediary should contact the institution within 7 days and should request a full refund, (2) if a full refund is not practicable, the intermediary and the institution should within 30 days agree upon a repayment schedule (e.g., recovery of the debt within a year through offset or periodic repayments), and (3) if such a repayment schedule cannot be agreed to within 30 days, the intermediary should unilaterally make offsets to future Medicare interim payments--full recovery would be made within 120 days from the initial contact.

With respect to obtaining refunds from institutions that had terminated from Medicare, the new instructions state that:

- If the intermediary identifies an overpayment any time during the cost-reporting and settlement process, the intermediary should contact the institution within 7 days and should request a full refund.
- If, within 30 days after the initial contact, a refund is not made, or an agreed-upon repayment

¹These instructions were issued to intermediaries in draft form in July 1970.

schedule is not established, the intermediary should send a formal demand letter to the institution requesting a full refund.

--If, as a result of the first demand letter, no refund is made or if an acceptable repayment schedule is not established, a second and a third demand letter should be sent to the institution at 30-day intervals, the third letter advising the institution that the debt is being referred to the General Accounting Office (GAO) for collection.

In other words, under SSA's September 1970 instructions, about a 3-month interval elapses between the time that an overpayment to a terminated institution is identified--and, if not recovered--the time the intermediary prepares the case for submission to SSA for referral to us.

NEED TO IMPROVE EFFORTS TO RECOVER
OVERPAYMENTS THROUGH OFFSETS

In numerous situations four of the five intermediaries included in our review did not recover known overpayments from institutions by offsetting them against other Medicare amounts due the institutions.

Our analysis of one intermediary's records pertaining to 42 terminated institutions during the 1-year period May 1969 through April 1970 showed that after SSA had notified the intermediary of their terminations, 38 institutions had received interim payments of about \$333,000 for services furnished before termination. Medicare overpaid one-half of these institutions. In some instances the intermediary was aware of the overpayments at the time the interim payments were made but did not make offsets.

For example, one institution terminated on June 30, 1969. The intermediary received notification of the termination from SSA about 2 weeks later. Although the intermediary's records showed that the institution had been overpaid about \$28,000, the intermediary made further payments to the institution of about \$14,000 for services provided to Medicare patients before termination. As of March 1971 the institution owed the program the overpayment outstanding at the time of its termination (\$28,000) plus \$18,000 later identified during an intermediary audit.

We noted that for 192 institutions that terminated between the start of the program and April 1970, the intermediary had made tentative settlement payments of about \$1 million to 65 institutions after their terminations. Of these 65 institutions, 19 had been overpaid \$119,000. Although the intermediary was aware of the overpayments at the time of the tentative settlement payments, it did not offset them against the payments.

Intermediary officials told us that procedures had been instituted about July 1970 for offsetting outstanding overpayments to institutions against other funds due the institutions before making tentative settlement payments. However, tentative settlement payments of \$17,645 were made to four of the above-mentioned 19 institutions in October and

November of 1970. Intermediary officials were unable to explain the reasons for making these tentative settlement payments and advised us that they planned to reevaluate the procedures which had been established in July 1970.

Three other intermediaries did not use similar opportunities to offset known overpayments. One intermediary continued to make interim payments to three institutions even though it was aware that they were indebted to the Medicare program. In December 1968 the intermediary learned that overpayments of \$15,000, \$19,000, and \$48,000, respectively, had been made to these institutions; however, the intermediary continued to make interim payments to them of \$289,000, \$59,000, and \$115,000, respectively. Thus, the total overpayments as of December 1968 could have been recovered by offset against the interim payments due the institutions. The three institutions terminated from Medicare during 1969. As of November 1970, these institutions were indebted to the program for overpayments of about \$73,000, \$78,000, and \$187,000, respectively.

One intermediary took advantage of the offset procedure for recovering overpayments to terminated institutions. Intermediary officials advised us that in September 1969 the intermediary had initiated a policy of withholding and putting in escrow any amounts due terminated institutions, and institutions which were to terminate, until all Medicare cost reports had been submitted and audits and settlements had been made. In July 1970 this intermediary was holding in escrow for possible offset about \$71,500 due 29 terminated institutions pending its determination of their liability to the program.

We recognize that a firm national policy of withholding interim payments from terminated institutions until there is an audit and a settlement of all their cost reports could result in inequities where the audit and settlement process extends over unduly long periods. Nevertheless, we believe that SSA's September 1970 instructions pertaining to offsets should be modified to provide that no interim payments be made to an institution after its termination unless (1) the institution's Medicare current-financing payments have been refunded or the liability has been accepted by a new owner, (2) any other known overpayments to the institution have

been collected, and (3) the intermediary is satisfied that it is unlikely that unidentified overpayments exist where cost reports either are outstanding or have not been audited.

EFFORTS TO OBTAIN REFUNDS
ONLY PARTIALLY SUCCESSFUL

Because SSA's September 1970 instructions (see p. 32) providing for systematic followup procedures were issued during our field reviews, we were unable to fully assess their effectiveness. Nevertheless, we did observe that both before and after the issuance of these instructions, intermediaries had communicated with terminated institutions in an effort to recover overpayments and that these efforts had not been particularly successful.

As discussed in chapter 3, overpayments to terminated institutions resulted primarily from making interim payments based on estimated costs which were more than the actual allowable Medicare-related costs. Such excess payments often were not determined until long after the institutions had terminated, when their annual cost reports were submitted and/or the intermediaries' audits had been made.

We reviewed the collection efforts of one intermediary pertaining to 11 terminated institutions for which about \$1.1 million in excessive interim payments applicable to various reporting periods had been identified by the intermediary. The results of such collection efforts as of February 1971, were as follows.

- For three institutions, which had been overpaid about \$300,000, either the overpayments were collected or repayment schedules were established.
- One institution owed about \$37,000, and although the intermediary had sent periodic demand letters after October 1970, no recoveries were made.
- The remaining seven institutions had been overpaid about \$760,000, of which about \$340,000 was recovered. Although the intermediary had sent some demand letters, the unrecovered balances of \$420,000 were outstanding for periods of up to about 3 years after the institutions had terminated.

We recognize that intermediaries' efforts to recover overpayments resulting from excessive interim payments may

be hampered because the amounts of the actual allowable Medicare-related costs may be subject to dispute. As discussed in chapter 3, however, Medicare current-financing payments are clearly refundable to the program upon termination, and in our opinion, there should be little or no dispute as to the amount or the validity of the debt. Nevertheless, intermediaries were often unsuccessful in collecting even these amounts from the terminated institutions.

For example, 116 institutions served by one intermediary owed Medicare about \$1,318,000 in current financing at termination. This amount was reduced by \$834,000 through transfers of liabilities of \$774,000 to the new owners of institutions that continued to participate and by collecting \$60,000 from one institution's new intermediary. The remaining \$484,000 had to be recovered from the terminated institution. As of November 1970, 38 institutions still owed \$259,000, which had been outstanding an average of 23 months after the termination dates. The recovery of \$225,000, or only about 45 percent of the amounts to be recovered, was accomplished by

--refunds of \$129,000, which took an average of 6 months to collect;

--offsets of \$53,000 against interim payments, which took an average of 17 months to make; and

--offsets of \$43,000 against final settlements.

In their comments to SSA on a draft of this report, BCA and one of the commercial intermediaries pointed out that difficulties in establishing ownership of terminated institutions or in locating officials who could be held accountable had contributed to the intermediaries' problems in collecting amounts due from terminated institutions.

MANY INSTITUTIONS HAVE NOT ACCOUNTED FOR MEDICARE INTERIM PAYMENTS

Intermediaries faced additional problems by not knowing the amounts due from terminated institutions because the institutions had not submitted cost reports accounting for interim payments and showing the amounts of overpayments, if

any. On the basis of the incidence of overpayments to terminated institutions that did file cost reports, we believe that it is probable that substantial additional overpayments also have been made to those terminated institutions that did not file reports.

About 1,500 cost reports were due from the 700 institutions included in our review at termination. As of November 1970, 227 institutions still owed the intermediaries 332 cost reports covering interim payments of about \$17 million. The submission of the 332 cost reports had been due for an average of about 2 years, even though cost reports were generally to be submitted to intermediaries within 3 months from the end of the annual reporting period or the termination date of an institution, whichever was applicable.¹

Obtaining cost reports from terminated institutions poses a problem which has been minimized for currently participating institutions. SSA issued instructions in September 1969 stating that, when an institution has not filed cost reports promptly, intermediaries must reduce or withhold interim payments due the institution. In the case of a terminated institution, however, such an incentive to submit cost reports could have only limited effectiveness because interim payments made to the institution could be expected to be curtailed shortly after its termination.

Under SSA's September 1970 instructions, when a terminated institution does not submit a cost report to the intermediary within the 3-month filing period, an overpayment for all unaccounted-for interim payments made to the institution exists. SSA's related followup procedures (see p. 32) provide for (1) an initial demand letter within 7 days after the cost report was due and (2) two followup letters at 30-day intervals, the second followup letter advising the institution that the case is being referred to us for collection.

¹See note 1, p. 10.

OVERPAYMENTS NOT UNDER ACCOUNTING CONTROL

We could not readily ascertain from the records maintained by two of the five intermediaries the amounts due either Medicare or an institution. For both intermediaries it was necessary to refer to several different sources of information to determine whether the institutions were indebted to Medicare and, if so, how much. Each intermediary maintained separate records showing current financing, accelerated payments, and interim payments. In some cases, errors were made on the separate records and it was necessary for us to refer to receipt and payment records to determine the amounts paid to or received from the institutions.

In our opinion, establishing an accounting record, which would show a balance due either the program or the institution and which could be reconciled with a central control account, would result in more accurate data for the intermediary with which to make offsets or claims for overpayments. Without such accurate data on which to base claims for refund, overpayments made to institutions could be overlooked and could result in losses to the Medicare program.

Both intermediaries informed us that they were establishing computer control systems which would provide current account balances for institutions receiving payments under the program.

CONCLUSIONS

Under the terms of their contracts with HEW, intermediaries are precluded from initiating court proceedings to recover overpayments. Therefore they have only limited administrative remedies for recovering overpayments from an institution. These remedies include (1) making offsets against other Medicare payments which may be due the institution and (2) sending letters demanding refunds of the overpayments.

The magnitude of the intermediaries' problems are evidenced by our reviews at the offices of five intermediaries in the three States which showed that at November 1970 (1) of the identified overpayments of \$8.1 million to institutions that terminated from Medicare from its

inception in fiscal year 1967 through April 1970; \$4.6 million, or 60 percent, remained outstanding and (2) of the 700 terminated institutions, 227, or 30 percent, had not filed cost reports to account for about \$17 million in interim payments made to them during their Medicare participation.

We believe that intermediary overpayment recovery actions could be improved by (1) taking greater advantage of opportunities to offset known overpayments against other payments due the institutions both before and after termination and (2) establishing accounting systems which would readily provide accurate data on the amounts due from the institutions so that both the offset and the followup collection procedures could be more effective.

RECOMMENDATIONS TO THE SECRETARY OF HEW

To facilitate more effective recovery actions at the intermediary level, we recommend that HEW through SSA:

- Emphasize to the intermediaries the need for stricter compliance with existing instructions for making offsets to recover outstanding overpayments.
- Expand these instructions to require intermediaries to withhold interim payments to terminated institutions unless (1) the institutions' Medicare current-financing payments have been refunded or the liability accepted by new owners, (2) other known overpayments have been collected, and (3) the intermediaries are satisfied that it is unlikely that unidentified overpayments exist.
- Emphasize to intermediaries the need to establish and maintain accounting controls which would enable a timely and accurate determination of the amounts due to or from institutions that had received Medicare payments.

HEW COMMENTS AND ACTIONS AND GAO EVALUATION

HEW, in commenting on our draft report, agreed with our recommendation that intermediaries need to comply more

fully with existing SSA instructions for making offsets and advised us that SSA had notified its regional offices to closely monitor this intermediary activity.

With regard to our recommendation that SSA instructions be expanded to require withholding interim payments to terminated institutions unless certain specific conditions have been met, HEW stated that SSA's existing instructions required intermediaries to adjust interim payments to avoid overpayments when an institution planned to terminate from Medicare.

Although we agree with HEW regarding the general objectives of existing SSA instructions, our review of the actual implementation of the instructions by the five intermediaries indicates that more specific instructions in line with our recommendation would be desirable because of the apparent reluctance of some intermediaries to take forceful actions in the absence of such specific direction from SSA. Our views in this regard have been reinforced by the fact that BCA--which through its subcontracts with 74 Blue Cross plans is by far the largest Medicare intermediary--expressed agreement with this recommendation in commenting to SSA on a draft of this report.

HEW agreed with our recommendation on the need for intermediaries to maintain control accounts which would readily provide information on the amounts due to or from institutions they serve. To implement this recommendation, HEW advised us, SSA had recently developed a system which will require intermediaries to report quarterly to SSA all outstanding overpayments to institutions, including those that have terminated, and the actions taken to recover the overpayments. (See pp. 45 and 47.) HEW pointed out that to carry out these reporting requirements, intermediaries would have to establish and maintain the control accounts we recommended.

CHAPTER 5

NEED TO IMPROVE FINANCIAL MANAGEMENT ASPECTS OF OVERPAYMENTS AT THE FEDERAL LEVEL

Under the procedures in effect in November 1971, SSA did not establish accounting controls over the overpayments or unaccounted-for payments made to terminated institutions until the cases were referred to us for collection. Of the cases we reviewed, these referrals represented only about 6 percent of the total outstanding overpayments and about 2 percent of the unaccounted-for interim payments. Without accurate information on the debtors, amounts due, length of time the debts have been outstanding, and other pertinent information affecting specific cases, SSA was not in a position to effectively discharge its responsibilities for collecting amounts due Medicare.

The Federal Claims Collection Act of 1966 (31 U.S.C. 951-953) places the responsibility with the administrative agencies for collecting debts due the United States which arise as a result of their activities. Each agency is required to develop a program and internal procedures to govern its efforts to recover amounts due the United States. In general, all debts which cannot be collected by the administrative agency are to be referred to us for further collection action. If we are unable to collect the debt, the matter may be referred to the Department of Justice for court proceedings or may be written off if it appears that legal action would not be productive.

Under SSA's September 1970 instructions, when an identified overpayment has been outstanding for about 3 months and the intermediary has not made arrangements for recovery or when a cost report from a terminated institution has been overdue for about 3 months, the intermediaries must prepare the case for submission to SSA for referral to us for further action.

For the five intermediaries reviewed, only a small portion of either the \$4.6 million in identified overpayments or the \$17 million in unaccounted-for interim payments as of

November 1970 had been submitted to SSA as of February 1971. Only a small portion of the cases submitted to SSA by the intermediaries had been referred to us as of November 1971.

--As of November 1970, information developed by the five intermediaries showed that 270 terminated institutions owed Medicare about \$4.6 million and that 227 terminated institutions had not filed cost reports to account for interim payments of about \$17 million.

--As of February 1971, the five intermediaries had submitted cases involving 43 institutions to SSA for referral to us. These cases pertained to 25 institutions with identified overpayments of about \$478,000 and to 34 institutions--including 19 of the 25--that had not filed cost reports to account for interim payments of about \$3.1 million.

--As of November 1971,¹ SSA had submitted nine cases to us for further collection action. These pertained to identified overpayments of about \$270,000 involving seven of the nine terminated institutions and unaccounted-for interim payments of about \$360,000 involving five of the nine terminated institutions.

--As of November 1971, of the nine cases submitted to us (1) two had been referred to the Department of Justice, (2) negotiations were in process with two institutions for a refund or for the submission of delinquent cost reports, (3) periodic letters were being sent to three institutions demanding collection or the submission of delinquent cost reports, and (4) the remaining two cases had been closed as uncollectible because the debtors did not have sufficient assets to make referrals to the Justice Department worthwhile.

¹Nationwide, as of November 1971, we had received 82 cases from SSA pertaining to identified overpayments of about \$2 million and unaccounted-for interim payments of about \$3.2 million. The status of these cases as of November 1971 is summarized in app. I.

In summary, of the overpayments and unaccounted-for interim payments that the intermediaries had identified in November 1970, only about 6 percent of the overpayments and 2 percent of the unaccounted-for interim payments had been referred to us by November 1971.

We recognize that during the 1-year period from November 1970 to November 1971, some of the amounts due could have been collected by the intermediaries and that some of the delinquent cost reports could have been filed. SSA was not in a position, however, to readily provide this information because it had not established an adequate management information system or related accounting controls over the identified overpayments or delinquent cost reports until after the cases had been submitted to us.

In other words, SSA did not have systematic controls to account for those cases which had been submitted by the intermediaries and which either were being processed within SSA or had been returned to the intermediaries for additional information. Further SSA did not have systematic controls to account for those cases involving identified overpayments or unaccounted-for interim payments to terminated institutions that had not been submitted to SSA by the intermediaries.

Establishing systematic Federal accounting controls of overpayments is also particularly important because under section 2415 of title 28 of the United States Code, the Government usually must initiate suit for recovering overpayments within 6 years after the right of action accrues. Therefore SSA should have the necessary controls to insure that uncollected overpayment claims are submitted to us at least 1 year before the expiration of the statutory period of limitation within which any suit usually must be brought.

RECENT STEPS BY SSA TO INITIATE CONTROLS

During 1971 HEW initiated action to develop procedures aimed at obtaining quarterly reports from the intermediaries showing overpayments to all institutions they served, including terminated and participating institutions. As of November 1971, however, the procedures had not been fully implemented and no reports had been received at the SSA

headquarters.¹ Also, during 1971, a section had been set up within SSA specifically to deal with problems in recovering Medicare overpayments, but as of November 1971, the section was not fully staffed.

CONCLUSIONS

Establishing accounting controls and related followup procedures over overpayments to institutions terminating their participation in Medicare is fundamental if SSA is to effectively manage its collection activities. Without such controls SSA management is not in a position to know whether (1) the overpayment problems at the intermediary level were getting better or worse, (2) the intermediaries were submitting uncollected accounts promptly as required by SSA's September 1970 instructions, (3) the cases returned to the intermediaries for additional information were being resubmitted promptly, or (4) overpayment claims were being submitted to us at least 1 year before the expiration of the 6-year statutory period of limitation.

Such controls should be initiated when an institution terminates from Medicare. Thereafter SSA should establish periodic intermediary reporting requirements and related followup procedures aimed at providing current overall information on the status of the terminated institutions' accounts until such time as each institution's liability to the program, if any, is satisfied or the case is referred to us for collection.

RECOMMENDATION TO THE SECRETARY OF HEW

We recommend that SSA establish management controls designed to provide current and meaningful information on the status of terminated institutions' Medicare accounts from the dates of their terminations until the accounts are paid or otherwise appropriately disposed of.

¹According to HEW, the first report under these procedures will cover all overpayments outstanding as of June 30, 1972. (See app. II, p.56 .)

HEW COMMENTS AND ACTIONS

HEW advised us that it concurred in our recommendation and, as noted on page 45, pointed out that SSA had recently developed a system for intermediaries to report quarterly to SSA on (1) all outstanding overpayments to institutions, including those which terminated from Medicare, and (2) the actions taken by the intermediaries to recover the overpayments. (See p.41.)

CHAPTER 6

TERMINATED INSTITUTIONS INDEBTED TO MEDICARE

CONTINUED TO BE PAID UNDER MEDICAID

As indicated in chapter 2, about 66 percent of the 136 institutions included in our review that voluntarily withdrew from Medicare continued to participate in the State Medicaid programs. Further, as of November 1970, about 60 percent of those institutions that had remained in Medicaid either had Medicare overpayments outstanding of about \$760,000 or had not submitted cost reports to account for Medicare interim payments of about \$1.3 million. After withdrawing from Medicare, these institutions received payments under Medicaid--including the Federal Government's share--which in most cases far exceeded the amounts they owed Medicare.

Although it is a general policy of the Federal Government to recover debts due the United States under one program by offsets against amounts due the debtor under other Federal programs, no statutory provision authorizes the offsetting against, or withholding of Medicare payments from, Medicaid payments or vice versa.

Under Medicaid, where payments to institutions are made by the States, the Federal Government has no right to recover from the States or to withhold Federal participation if the State uses the funds properly and complies with the Medicaid statute, regardless of who is providing the Medicaid services. Under Medicaid the Federal Government pays from 50 to 83 percent of the costs incurred by the States. We believe that HEW participation in Medicaid payments to institutions which are indebted to Medicare or which refuse to submit cost reports to properly account for their past Medicare payments does not further the Government's interests in achieving efficient and effective administration of these programs.

INSTITUTIONS VOLUNTARILY WITHDRAWING FROM
MEDICARE CONTINUED MEDICAID PARTICIPATION

Of the 700 terminated institutions included in our review, 136 voluntarily withdrew. We ascertained the status of Medicaid participation for these institutions. The remaining institutions were not likely to participate in Medicaid after terminating from Medicare for the following reasons.

- In many instances the termination action involved a change of ownership. Although the facility itself could continue in both Medicare and Medicaid under the new owners, the organizational entities (e.g., former owners) responsible for the Medicare debts might not be directly responsible for the institution's current activities under either program.
- In some instances HEW initiated termination because of the institution's failure to comply with Medicare health and safety requirements which are generally similar to Medicaid's.
- In other instances the institutions discontinued operating.

Of the 136 institutions (18 hospitals and 118 ECFs) that voluntarily withdrew, 90 (one hospital and 89 ECFs) continued to participate in Medicaid. Of the 89 ECFs which continued to participate in Medicaid as skilled nursing homes, 52 either had Medicare overpayments of about \$760,000 and/or had not filed cost reports to account for about \$1.3 million in Medicare interim payments. Of these 52 institutions which either owed Medicare or had delinquent cost reports, 46 had received payments under the Medicaid program amounting to about \$8.9 million after their withdrawal.

For example, one institution withdrew during January 1970. After withdrawing the institution was paid about \$96,000 under Medicaid through August 1971. As of November 1970, the institution owed Medicare about \$20,400 because of an overpayment made during the institution's reporting period ended September 30, 1967. The intermediary did not determine the extent of this overpayment until January 1970

when it audited the institution's cost reports submitted September 1969. As of November 1970, the institution also had not accounted for Medicare interim payments of about \$97,500 for services provided before its withdrawal.

Another institution, after withdrawing in December 1969, was paid about \$329,000 under the Medicaid program through June 1971. As of November 1970, the institution owed Medicare about \$81,300 because of overpayments made during its reporting periods ended December 1967 and 1968. The institution also did not file a cost report to account for Medicare interim payments of about \$101,000 for its reporting period ended December 1969.

Nationwide, as of December 1970 and December 1971, 1,640 and 2,145 institutions, respectively, had voluntarily withdrawn from Medicare. These represented about 41 percent and 43 percent of the total terminations as of those dates. (See p. 15.) On the basis of our reviews involving five Medicare intermediaries in three States, which showed that about 66 percent of the institutions voluntarily withdrawing from Medicare continued to participate in Medicaid, it appears to us that if HEW had the authority to withhold Federal participation in Medicaid payments to such institutions, such authority could be a useful tool to facilitate the recovery of Medicare overpayments or to obtain delinquent Medicare cost reports.

As an indication of the usefulness of withholding payments as a means of obtaining delinquent cost reports, in September 1969 SSA instructed its intermediaries to reduce or suspend Medicare interim payments to institutions that failed to submit cost reports promptly. After this policy had been initiated, SSA statistics showed that there were significant improvements in the timely submission of Medicare cost reports by participating institutions.

As previously noted, however, in the case of terminated institutions, the reduction or suspension of Medicare interim payments could not be particularly effective because such payments would be expected to be curtailed shortly after termination. On the other hand, if a terminated institution continued to participate in Medicaid, the authority to withhold Medicaid payments to encourage submitting

overdue Medicare cost reports could, in our opinion, produce similar beneficial results as evidently resulted from SSA's September 1969 instructions on institutions actively participating in Medicare.

CONGRESSIONAL DELIBERATIONS AIMED AT
IMPROVING MEDICARE AND MEDICAID

As discussed in chapter 2, from 1970 to 1972 the Congress has been considering certain amendments to the Medicare and Medicaid laws which would emphasize improving the programs' operating affectiveness.

Among the legislative proposals aimed at achieving closer and more effective coordination in administering Medicare and Medicaid is an amendment which would authorize the Secretary of HEW to terminate or suspend Medicare payments for services rendered by institutions found guilty of program abuses, such as furnishing inferior services or consistently overcharging for their services. This proposal was included in both the Senate's December 1970 version of House bill 17550 and the House's June 1971 version of House bill 1.

This proposed amendment further provides that there be no Federal financial participation in any State Medicaid payments with respect to services furnished by an organization whose Medicare payments the Secretary had terminated. To insure that the affected institutions are not treated unfairly, the proposed amendment states that any institution dissatisfied with the Secretary's decision to terminate or suspend Medicare payments is entitled to a hearing by the Secretary and to judicial review of the Secretary's final decision.

With respect to the specific problem of recovering Medicare overpayments made to terminated institutions, another proposed amendment would authorize the Secretary of HEW to establish liens in favor of the United States in the amount of the overpayment on all the property of the institution where a determination of an overpayment has been made or where an overpayment issue is being contested.

In explaining the foregoing proposal, the December 11, 1970, report of the Senate Committee on Finance (S. Rept. 91-1431) accompanying House bill 17550 pointed out that:

"The committee is concerned because, in dealing with the problem of recovery of overpayments to

providers of services, it has found that an effective administrative remedy to protect the interests of the Government does not exist in certain cases. These cases involve (1) providers who have terminated their participation in the program, and who refuse to refund any money to meet the debt incurred by an overpayment; and (2) providers who continue to participate in the Medicare program, but who have very low utilization by Medicare beneficiaries with the result that little or no Medicare payments are due the provider.

"If a provider refuses to refund, the Department's recourse in such a situation is to send demand letters at prescribed intervals and, if this action does not result in a refund, to refer the case to the General Accounting Office for collection. If GAO is unsuccessful in obtaining refund, the case may be referred to the Department of Justice for legal action. The committee is concerned, however, that until the case is referred to the Department of Justice, no effective administrative action can be taken to prevent dissipation or diversion of assets by the provider while recovery efforts are being conducted. During this time, the provider has had Government funds at his disposal on which he does not have to pay interest. Furthermore, he has time to dispose of his assets so that if legal action is ever undertaken to collect the debt, there may not be any assets available to meet the obligation. If, however, a lien in favor of the Government in the amount of the overpayment was placed upon the property of the provider, the assets of the provider would be conserved while the Government is taking the necessary collection action."

The House's June 1971 version of House bill 1 did not include a similar amendment authorizing the Secretary of HEW to establish liens. As of June 1972, House bill 1 was being considered by the Senate Committee on Finance, but we understand that the Committee does not plan to include a lien provision in its version of the bill.

RECOMMENDATION TO THE CONGRESS

In view of the congressional intent to achieve closer and more effective coordination between Medicare and Medicaid and in view of the expressed congressional concern with the problems in recovering overpayments from terminated institutions, we recommend that the Congress provide the Secretary of HEW with the authority to withhold--subject to appropriate advance notice to a State--Federal participation in State Medicaid payments to those terminated institutions which refuse to refund Medicare overpayments or to submit cost reports to account for Medicare payments received.

We recognize that such authority would not provide a complete solution to the problem of recovering overpayments. We believe, however, that the existence of such authority could help to stimulate action on the part of institutions to settle their Medicare debts and also could be of help in dealing with those withdrawn institutions that refuse to submit Medicare cost reports and which continue to receive Medicaid payments.

CONGRESSIONAL ACTION

In February 1972 we furnished a copy of a draft of this report to the Senate Committee on Finance in accordance with the Committee's request.

On March 20, 1972, the Committee announced that, in its deliberations on the Social Security Amendments of 1971 (H.R. 1), it had decided to initiate an amendment to the Social Security Act which would give the Secretary of HEW the authority to withhold (subsequent to 60 days advance notice to a State) future Federal financial participation in State Medicaid payments to institutions which have withdrawn from Medicare without refunding Medicare overpayments or submitting cost reports to account for Medicare payments made to them during their participation.

STATUS OF 82 MEDICARE CASES
REFERRED TO GAO FOR
COLLECTION AS OF NOVEMBER 1971

	Number of <u>cases</u>	Identified over- <u>payments</u>	Amounts unaccounted for because of failure to file <u>cost report</u>
Amounts collected or periodic pay- ments being made	4	\$ 63,000	\$ -
Cost reports re- ceived and case being reconsid- ered on the basis of cost data	5	49,000	189,000
Case being recon- sidered on the basis of new in- formation received from institution	9	273,000	144,000
Referred back to HEW	3	2,000	53,000
Demand for refund or cost reports being made	33	1,008,000	1,273,000
Referred to Justice Department	20	563,000	1,096,000
Case closed (note a)	<u>8</u>	<u>57,000</u>	<u>398,000</u>
Total	<u>82</u>	<u>\$2,015,000</u>	<u>\$3,153,000</u>

^aIn four cases there were insufficient assets to pay the claims, and in four additional cases the whereabouts of the debtors were unknown.

APPENDIX II



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

MAY 22 1972

Mr. John D. Heller
Acting Associate Director
Management and Welfare Division
U.S. General Accounting Office
Washington, D. C. 20548

BEST DOCUMENT AVAILABLE

Dear Mr. Heller:

The Secretary has asked me to reply to your letter dated January 31, which transmitted copies of your draft report, "Sizeable Amounts Due the Government by Institutions that Withdrew from the Medicare Program, B-164031(4)."

We are enclosing a statement setting forth the Department's comments with respect to the findings and recommendations contained in the report. Also enclosed are comments submitted by the [intermediaries.]

[See GAO note.]

Sincerely yours,

A handwritten signature in cursive script, appearing to read "J. B. Cardwell".

James B. Cardwell
Assistant Secretary, Comptroller

Enclosures

GAO note: This report deals with only selected aspects of the intermediaries' various functions under their contracts with HEW which may or may not be indicative of the intermediaries' overall performance. Therefore, the intermediaries are not identified in the report, and, although their comments are referred to in the report, these comments are not included as appendixes.

COPY

SIZEABLE AMOUNTS DUE THE GOVERNMENT BY INSTITUTIONS
THAT WITHDREW FROM THE MEDICARE PROGRAM
(GAO Draft Report to the Congress, B-164031-04)

The draft report discusses (1) the reasons why "substantial" numbers of health care institutions have withdrawn from participation in the Medicare program, and (2) the problems related to overpayments made to some of these institutions. GAO's review focused on five intermediaries which in three States--California, Massachusetts, and Texas--had serviced about 700 extended care facilities (ECFs) and hospitals that, through April 1970, had terminated their Agreements to participate in Medicare. The report states that at November 1970, 270 of these institutions still owed the program \$4.6 million.

With respect to the "institutions" that have terminated their agreements to participate in Medicare, we would like to point out that most were ECF's; relatively few were hospitals. Being smaller and mostly privately owned, profit-motivated organizations, ECF's are susceptible to quick sale by their owners. A majority of these sales, however, result only in a change of ownership, with the facilities themselves remaining in the Medicare program. In fact, of the 3,800 institutions whose agreements had been terminated by December 1970, about 37 percent had undergone changes in ownership with the new owners participating - under new agreements - in the program.

Since the time that GAO completed its field work, SSA has made a number of important modifications in the administration of the program which have afforded the Bureau of Health Insurance (BHI) more effective control over provider reimbursement and, by the same token, over potential overpayments. For example, the resident representative program--whereby BHI employees at the intermediaries and carriers focus in on selected issues--and the continuing decentralization of administrative responsibilities to the field, tend to bring management resources to bear more immediately and directly on the types of overpayment problems discussed in the report. In addition to establishing policies and procedures for identifying and recovering overpayments (Provider Reimbursement Manual section 2409 ff, Part A Intermediary Manual section 2228 ff, and Health Insurance Regional Office Manual section 5200 ff) SSA has developed surveillance programs for concentrating on and correcting the conditions which tend to create overpayments.

1. Recommendation: Emphasize the need for stricter compliance by intermediaries with the existing requirements, particularly in the use of current cost data, in determining and periodically reviewing interim rates for hospitals and ECFs.

We concur that intermediaries should closely comply with requirements that current cost data be used in determining and periodically reviewing interim rates for hospitals and ECF's. This is set out in the "Principles of Reimbursement." In

APPENDIX II

order to better monitor this activity, we have--as previously brought out-- established the resident representative program, and decentralized many administrative responsibilities to the field. In addition, we have developed surveillance programs for concentrating on and correcting conditions which tend to create overpayments. These programs will act to more quickly focus management resources on this as well as other areas of intermediary activity.

2. Recommendation: Revise SSA procedures to require its intermediaries to be notified on a timely basis of institutions that intend to withdraw or have withdrawn from Medicare in order to help minimize overpayments resulting from unrefunded current financing payments.

Existing SSA instructions to regional offices call for the intermediary to be notified in all instances where a provider voluntarily or involuntarily ends its participation in the program. We will advise all regional offices of the situation noted by GAO, and will remind them of the need to promptly notify the intermediary whenever they learn that a provider has terminated, or intends to terminate, its agreement.

3. Recommendation: Emphasize to the intermediaries the need for stricter compliance with existing instructions for making offsets to recover outstanding overpayments.

We concur that intermediaries need to comply more fully with instructions for making offsets. We have notified our regional offices to closely monitor this intermediary responsibility and to direct that remedial action be taken when necessary.

4. Recommendation: Expand SSA's instructions to require the withholding of interim payments to withdrawn institutions unless (1) the institutions' Medicare current financing payments have been refunded and (2) the intermediary is satisfied that it is unlikely that the institution had been overpaid.

Existing program instructions (Part A Intermediary Manual section 2800.1) require intermediaries to adjust the interim payment, current financing payment, or accelerated payment as necessary to prevent an overpayment where a provider plans to withdraw from the program. In our opinion, the conditions noted by GAO do not require further refinement of our instructions at this time. We will continue to review and evaluate these instructions and to revise and expand them were indicated.

5. Recommendation: Emphasize to intermediaries the need to establish and maintain accounting controls which would enable a timely and accurate determination of the amounts due to or from institutions that had received Medicare payments.

We concur with GAO's views on the need for intermediaries to maintain control accounts which supply ready information on amounts due to or from its providers. A system has been developed which will require intermediaries to report to SSA, on a quarterly basis, all outstanding provider overpayments and the actions taken

to recover them. The first report under this system will cover all overpayments outstanding as of June 30, 1972. In order to carry out these reporting requirements, intermediaries will have to establish and maintain the type of control accounts envisioned by GAO.

6. Recommendation: Provide for the establishment of management controls designed to provide SSA with current and meaningful information on the status of withdrawn institutions' Medicare accounts from the time they withdrew from the program until the accounts are paid or otherwise appropriately disposed of.

We concur in this recommendation. Under the preceding recommendation we described a recently developed system for reporting to SSA all outstanding overpayments to providers and the intermediaries' efforts at recovery. This reporting system will require specific identification of all overpayments to institutions that have withdrawn from the program. When it is implemented it will provide SSA, on an ongoing basis, with improved management control over all provider overpayments outstanding.

APPENDIX III

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

	<u>Tenure of office</u>	
	<u>From</u>	<u>To</u>
SECRETARY OF HEALTH, EDUCATION, AND WELFARE:		
Elliot L. Richardson	June 1970	Present
Robert H. Finch	Jan. 1969	June 1970
Wilbur J. Cohen	Mar. 1968	Jan. 1969
John W. Gardner	Aug. 1965	Mar. 1968
ADMINISTRATOR, SOCIAL AND RE- HABILITATION SERVICE:		
John D. Twiname	Mar. 1970	Present
Mary E. Switzer	Aug. 1967	Mar. 1970
COMMISSIONER OF SOCIAL SECURITY:		
Robert M. Ball	Apr. 1962	Present
DIRECTOR, BUREAU OF HEALTH IN- SURANCE (note a):		
Thomas M. Tierney	Apr. 1967	Present
Arthur E. Hess	July 1965	Apr. 1967

^aThe Bureau of Health Insurance was a part of the Bureau of Disability and Health Insurance until September 1965. At that time separate bureaus were established to handle the functions of the disability program and the health insurance program.

Copies of this report are available from the U. S. General Accounting Office, Room 6417, 441 G Street, N W., Washington, D.C., 20548.

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