REPORT TO THE CONGRESS

Ineffective Controls Over Program Requirements Relating To Medically Needy Persons Covered By Medicaid B-164031(3)

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

BY THE COMPTROLLER GENERAL OF THE UNITED STATES

JULY 28, 1971

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

B-164031(3)

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

This is our report on ineffective controls over program requirements relating to medically needy persons covered by Medicaid. Medicaid is a grant-in-aid program administered at the Federal level by the Social and Rehabilitation Service, Department of Health, Education, and Welfare.

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

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

Comptroller General
of the United States

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D I G E S T

WHY THE REVIEW WAS MADE

Under Medicaid, the Department of Health, Education, and Welfare (HEW) shares with the States the costs of providing medical care to persons unable to pay. About $4.8 billion was spent under the program during fiscal year 1970; the Federal share was $2.4 billion.

There are basically two types of persons who qualify under Medicaid.

--Those receiving public assistance payments under the Social Security Act (called categorically needy persons).

--Those whose financial resources are not sufficient to meet the costs of necessary medical care but who do not qualify for public assistance (called medically needy persons).

It is the option of the States whether medically needy persons receive benefits under Medicaid. Also, medically needy persons often must pay a share of the costs of medical care provided to them. This report is concerned only with payments made for the medically needy.

Of the 52 States and jurisdictions which have Medicaid programs, 27 have elected to provide coverage to the medically needy as well as to persons receiving public assistance.

The General Accounting Office (GAO) reviewed this aspect of the administration of the Medicaid program in California, Illinois, and Massachusetts. Total program expenditures in these States during fiscal year 1970 amounted to $1.4 billion, or about 30 percent of all Medicaid expenditures for that year.

FINDINGS AND CONCLUSIONS

Recipients' share of cost paid by Medicaid

California, Illinois, and Massachusetts provide services under the Medicaid program to about 413,000 medically needy persons. Each State has

encountered difficulties in administering this aspect of the program, and Medicaid has paid for medical services that should have been paid for by recipients. For example, on the basis of its review of a sample of Medicaid claims, GAO estimates that:

--For three county-operated hospitals in Los Angeles, claims paid by Medicaid during 1969, which should have been paid by the medically needy recipients, may have amounted to $1.6 million. Also, during 1969, Medicaid payments in the county on claims for physician services, drugs, and other medical services, which should have been paid by the recipients, may have amounted to $900,000. These payments occurred because the State had paid claims for services on behalf of persons who were not eligible or who had failed to pay their required share of the cost. (See pp. 11 to 19.)

--In the city of Boston claims paid by Medicaid during the 7-month period ended October 1969, which should have been paid by the medically needy recipients, may have amounted to $61,500. Such payments occurred because the State did not have a system, other than for nursing-home care, to ensure that the recipients' share of the cost was met prior to its paying claims for medical services. (See pp. 19 and 20.)

In Cook County, Illinois, GAO's review of Medicaid payments for eight hospital cases showed that about $17,700 paid by Medicaid should have been paid by the medically needy recipients. These payments--made during eligibility periods encompassing up to 18 months--occurred because the State had an ineffective system for ensuring that hospitals determined the recipients' share of cost and made deductions from the claims before submitting them to the State for payment. The great majority of Cook County's medically needy cases involved nursing-home care, and the county's procedures for obtaining the share of cost in these cases were generally effective. (See pp. 21 and 22.)

Limited HEW regional staffing contributed to these problems. (See pp. 25 and 26.)

Need to ensure States' compliance with limitation on Federal share of Medicaid costs

For States which elect to provide assistance to medically needy persons, the Social Security Act specifies a limitation on the extent of the Federal share of the costs. This limitation provides a maximum amount of annual family income for maintenance needs (food, shelter, clothing) to be used in computing the family share of cost to be applied to medical bills.

States may specify income levels above the Federal maximum, but the Federal share of medical costs will be limited to the amount which would have been allowable if the Federal maximum had been used. California's

income levels for the medically needy for 2- and 3-member families exceeded the Federal maximum. HEW, however, did not limit California's claims for Federal funds to amounts based on computations using the Federal maximum. Income levels in Illinois and Massachusetts did not exceed the Federal maximum.

HEW paid States' claims for medical costs of persons in seven other States which had established income levels that exceeded the Federal limits without determining whether the States had implemented procedures to limit such claims to amounts based on the Federal maximum. (See p. 29.)

Improvements needed in quality control systems

The quality control system prescribed by HEW provided for a systematic and continuous control by State agencies over the correctness of decisions reached by local welfare agencies, including those pertaining to eligibility.

In California and Massachusetts the quality control systems had been ineffective.

--Quality control data in California had not been tabulated, analyzed, or reported to HEW; therefore, causes of significant problems relating to share-of-cost determinations had not been identified. (See pp. 34 and 35.)

--In Massachusetts, quality control reviews had not been made from April 1968 to July 1969. During this period, HEW and the State had no assurance that the eligibility and share-of-cost determinations being made by individual caseworkers were correct. (See pp. 35 and 36.)

The effectiveness of the quality control system in Illinois was reduced because the State had reviewed less than the minimum number of cases specified by HEW. (See pp. 36 and 37.)

RECOMMENDATIONS OR SUGGESTIONS

HEW should

--evaluate the control systems in the 27 States which currently include medically needy persons under their Medicaid programs to identify those procedures most effective for ensuring that the recipients' share of cost is met for both institutional and noninstitutional services (see p. 26),

--after identifying these procedures, either (1) disseminate the information to the States with the recommendation that the procedures be followed or (2) develop a model system for use by the States (see p. 26),

--consider the practicability of controlling the administration of the recipients' share of cost in cases in which the amount is small or the required controls are burdensome (see p. 26),

--consider alternative approaches to cost sharing if it is determined that the administration of the present share-of-cost aspect of the program cannot be made practicable (see pp. 26 and 27),

--seek appropriate adjustments for improper payments charged to Medicaid because of failure of those county-operated hospitals in California to verify eligibility or to deduct the recipients' share of cost from Medicaid claims (see p. 27),

--provide for follow-up action to be taken by its regional office officials to ensure compliance with the statutory income limitations whenever the States' approved income levels are in excess of the Federal limitation (see p. 32), and

--review the action taken by California to improve its quality control system and monitor the progress of Massachusetts and Illinois in meeting their quality control objectives (see pp. 35 to 37).

AGENCY ACTIONS AND UNRESOLVED ISSUES

HEW stated that it was in general agreement with the conclusions and recommendations in this report, and it informed GAO of the corrective action it had taken or was taking on each recommendation. HEW stated also that it was following up on corrective actions being taken by the States. (See pp. 27, 28, 32, 35, 36, and 38.)

GAO believes that administrative actions taken, or promised, by HEW should, if properly implemented, help to improve the effectiveness of controls over program requirements relating to medically needy persons covered under the Medicaid program.

MATTERS FOR CONSIDERATION BY THE CONGRESS

This report contains no recommendations requiring legislative action by the Congress. It does contain information on weaknesses in agency administration, suggestions for correction or improvement, and proposals for improvement by the agency. This information should be of assistance to committees of the Congress and to individual members of Congress in connection with their legislative oversight responsibilities relating to the Medicaid program.

Contents

ABBREVIATIONS

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

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CHAPTER 1

INTRODUCTION

DESCRIPTION OF MEDICAID PROGRAM

The Medicaid program--authorized by title XIX of the Social Security Act, as amended (42 U.S.C. 1396)--is a grant-in-aid program under which the Federal Government participates in costs incurred by the States in providing medical assistance to persons who are unable to pay for such care. Medicaid is administered at the Federal level by the Social and Rehabilitation Service of the Department of Health, Education, and Welfare.

The services provided to Medicaid recipients vary from State to State; however, as a minimum, all States must provide inpatient hospital services, outpatient hospital services, laboratory and X-ray services, skilled nursing-home services, and physician services. As of April 1971, 48 States and the District of Columbia, Guam, Puerto Rico, and the Virgin Islands had adopted Medicaid programs.

The Federal Government pays from 50 to 83 percent (depending on the per capita income in the States) of the costs incurred by States in providing medical services under their Medicaid programs. For fiscal year 1970, the States and jurisdictions then having Medicaid programs reported expenditures of about $4.8 billion, of which about $2.4 billion represented the Federal share.

ADMINISTRATION OF MEDICAID PROGRAM

At the Federal level, the Secretary of Health, Education, and Welfare has delegated the responsibility for the administration of the Medicaid program to the Administrator of the Social and Rehabilitation Service. Authority to approve State plans for State Medicaid programs has been further delegated to the Regional Commissioners of the Service who administer the field activities of the program through HEW's 10 regional offices.

Under the act the States have the primary responsibility for initiating and administering their Medicaid programs.

The nature and scope of a State's Medicaid program are contained in a State plan which, after approval by a Regional Commissioner of the Service, provides the basis for Federal grants to the State. Also, the Regional Commissioners are responsible for determining whether the State programs are being administered in accordance with the Federal requirements and the provisions of the State's approved plan. HEW's Handbook of Public Assistance Administration provides the States with Federal policy and instructions on the administration of the several public assistance programs. Supplement D of the handbook and the Service's program regulations prescribe the policies, requirements, and instructions relating to the Medicaid program.

As part of our continuing examination into the manner in which HEW is discharging its responsibilities relative to the Medicaid program, we have examined payments made for Medicaid recipients who have an obligation to pay for part of their medical care. Our examination was conducted in California, Illinois, and Massachusetts. Since May 1970 we have issued eight reports to the Congress on other aspects of the Medicaid program; these reports are listed in appendix IV.

The HEW regional offices in San Francisco, Chicago, and Boston provide general administrative direction for the Medicaid programs in California, Illinois, and Massachusetts, respectively.

The HEW Audit Agency is responsible for audits of the manner in which Federal and State responsibilities for the Medicaid program are being discharged.

MEDICAID PROGRAM COVERAGE

Persons receiving public assistance payments under other titles[1] of the Social Security Act are entitled to

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

benefits under the Medicaid program. Almost all of the other persons covered by Medicaid are persons whose income or other financial resources exceed standards set by the States to qualify for public assistance programs but whose resources are not sufficient to meet the costs of necessary medical care. Coverage of this latter group is at the option of the States. Those persons receiving public assistance payments generally are referred to as categorically needy persons, whereas other eligible persons generally are referred to as medically needy persons.

As of July 1970, 27 States or jurisdictions had Medicaid programs covering both the categorically needy and the medically needy; 25 States or jurisdictions had programs covering only the categorically needy. As of July 1970, about five million medically needy persons were receiving Medicaid benefits.

Categorically needy persons are not required to make any payments from their own funds for medical expenses covered by State Medicaid programs, whereas medically needy persons usually are required to pay part of their medical expenses. The medical expenses which these persons must pay before Medicaid assistance is provided are referred to in this report as the recipients' share of cost. Each recipient's share of cost is computed by deducting what the State has established as necessary for basic living expenses from a person's income or other resources. The remainder (recipient's share of cost) is the amount of medical cost that must be incurred by the recipient before Medicaid will pay.

MEDICAID PROGRAM IN CALIFORNIA, ILLINOIS, AND MASSACHUSETTS

The Medicaid program in California became effective March 1, 1966, and the State Department of Health Care Services is responsible for administering the program. In Illinois the Department of Public Aid administers the Medicaid program which became effective January 1, 1966. In Massachusetts the Department of Public Welfare is the State

agency responsible for administering Medicaid which became effective September 1, 1966.[1]

The Federal Government pays 50 percent of the medical services and administrative costs of Medicaid in each of the three States and 75 percent of costs attributable to the compensation or training of medical personnel and supporting staff. During fiscal year 1969 California, Illinois, and Massachusetts reported Medicaid expenditures of about $1.2 billion, as shown below.

	California	Illinois	Massachusetts	Total
	(000,000 omitted)			
Expenditures on behalf of:				
Categorically needy persons	$495	$ 97	$ 73	$ 665
Medically needy persons	270	69	168	507
Total	$765	$166	$241	$1,172

These three States accounted for about 30 percent of all Medicaid expenditures in fiscal year 1969.

The following table shows the total number of persons who were covered under the Medicaid program in these States at June 30, 1969.

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[1]From September 1, 1966, through June 30, 1968, administration was handled by the welfare offices of individual towns and cities and overall supervision was provided by the Department of Public Welfare. Effective July 1, 1968, the responsibility for administering the Medicaid program was transferred to the Department of Public Welfare. Also, in Massachusetts, the State Commission for the Blind administers the Medicaid program for the blind. We did not review this aspect of the program because of the relatively small expenditures ($2 million) made in fiscal year 1969.

	California	Illinois	Massachusetts	Total
		(000 omitted)		
Categorically needy persons	1,555	410	276	2,241
Medically needy persons	200	63	150	413
Total	1,755	473	426	2,654

We examined into the administration of the program for medically needy persons in Los Angeles County and Cook County and the city of Boston. Information concerning recipients' share of cost of medically needy persons was not available at HEW on a nationwide basis, nor was it available on a statewide basis in California or Massachusetts. On the basis of our work in Los Angeles County, we estimate that the recipients' share of cost for a 1-month period in California was $4 million at the time of our fieldwork (about $1 million in Los Angeles County). We were unable to obtain data to make a similar estimate for Massachusetts; however, we estimated that, in the city of Boston, the recipients' share of cost was about $100,000 a month. In Illinois, recipients' share of cost was computed twice a year on a 6-month basis, and the State advised us that the recipients' share of cost was about $7 million for a 6-month period (about $3 million in Cook County).

If the average share of cost for each recipient in the areas which were included in our review was representative of the share of cost for all medically needy recipients in the 27 States or jurisdictions in July 1970, then the recipients' share of cost, on a nationwide basis, would be about $1.8 billion a year.

COMPUTATION OF RECIPIENTS' SHARE OF COST

HEW's Social and Rehabilitation Service program regulation 40-7, dated January 28, 1969, provides that (1) in determining eligibility, State plans allow the medically needy the same exclusions in arriving at net income and resources as are allowed in the State's public assistance programs and (2) only such excess income and resources as are actually available within a period--preferably of not more than

3 months but not in excess of 6 months ahead--including the month in which medical services were rendered, be considered as available to meet medical expenses.

We found that widely different policies existed in California, Illinois, and Massachusetts concerning allowances for work-related expenses in computing recipients' share of cost. An example illustrating how a recipient's share of cost would have been computed in each of these States at the time of our fieldwork is presented in appendix II.

In a letter dated March 11, 1971, commenting on a draft of this report, HEW informed us that, in view of the widely differing policies among the States concerning allowances for work-related expenses, HEW policies were being clarified.

CHAPTER 2

RECIPIENTS' SHARE OF COST PAID BY MEDICAID

California, Illinois, and Massachusetts use different methods to ensure that recipients are eligible for Medicaid; that, in the case of medically needy persons, their share of cost has been properly computed; and that recipients have incurred medical expenses at least equal to their share of cost before medical expenses are paid under the Medicaid program. Each of the States needs to improve its method of ensuring that these conditions have been met before paying for services under Medicaid. For each location included in our review, the States had paid for medical services that should have been paid for by the recipients. On the basis of our review of a sample of Medicaid claims, we estimated that:

--For three county-operated hospitals in Los Angeles, claims paid by Medicaid during 1969 which should have been paid by the medically needy recipients may have amounted to $1.6 million. Also, during 1969, Medicaid payments in the county on claims for physician services, drugs, and other medical services, which should have been paid by the recipients, may have amounted to $900,000.

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In Cook County, Illinois, our review of Medicaid payments for eight hospital cases showed that about $17,700 paid by Medicaid should have been paid by the medically needy recipients. These payments were made during eligibility periods encompassing up to 18 months.

Officials of each State advised us that they were having difficulty in trying to design and implement an adequate

system to help ensure proper determinations of the recipients' share of cost and that HEW had not given the States any guidelines or technical assistance to help them establish such a system. Details on the practices at each of the locations visited by us follow.

LOS ANGELES COUNTY

Payments to providers for services rendered to Los Angeles County Medicaid recipients are made by two fiscal agents.[1] Hospital and nursing-home claims are paid by the Hospital Service of Southern California, and all other claims (such as those for physician services and drugs) are paid by the California Physicians Service. State instructions to the fiscal agents require that claims submitted for services provided to a medically needy recipient who is responsible for paying a part of the cost should not be paid unless (1) a listing completed by the recipient showing the medical expenses incurred to meet the recipient's share of cost is attached or (2) the provider certifies on the claim submitted that the recipient has shown him a listing indicating that the recipient's share of cost has been met.

Claims submitted by county-operated hospitals

In November 1967 the State authorized the Hospital Service of Southern California to pay claims submitted by county-operated hospitals in Los Angeles County for services provided to medically needy persons without verifying their eligibility for Medicaid. This authorization was based on the State's understanding that the county had (1) sufficient confidence in its hospital admission practices, which included verification of eligibility with the local welfare office, that claims for ineligible persons would not be submitted and (2) accepted liability for any improper claims. In January 1968 the State offered to hospitals operated by other counties an opportunity to use this procedure. As of September 1970, 15 other counties had accepted this offer.

During 1969 the nine hospitals operated by the county of Los Angeles submitted to the fiscal agent Medicaid claims amounting to $25 million for services provided to the medically needy. Three of these hospitals accounted for about $20 million, or 80 percent of the amount claimed. At these three hospitals we sampled 312 of the claims submitted in

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[1] Fiscal agents are private organizations assigned Medicaid functions and responsibilities under contract with the States.

December 1969. As shown in the following table, 128 of the 312 claims were submitted without appropriate deductions having been made for the recipients' share of cost or were submitted for persons whose Medicaid eligibility had expired.

	Number of claims					
			Recipients' share of cost			
	Examined	Eligibility expired	Correct deduction made	Correct deduction not made	Total amount Claimed	Total amount Paid in error
Inpatient	143	6	107	30	$193,870	$12,201
Outpatient	169	41	77	51	9,787	4,573
Total	312	47	184	81	$203,657	$16,774

The three hospitals had procedures for verifying the eligibility for outpatient services at the time of a person's first visit to the hospital but did not have procedures for rechecking eligibility during subsequent visits. As a result, persons whose eligibility had expired because of changed family or financial circumstances continued to receive Medicaid outpatient services. Of the 169 outpatient claims which we examined, about 25 percent were for ineligible persons.

The eligibility of inpatients was determined upon admission by each of the three hospitals; however, eligibility was not rechecked during a patient's stay. In cases where a long stay was involved and eligibility circumstances changed, incorrect payments resulted. We found six such cases among the 143 inpatient claims which we examined.

We found that, at two of the three hospitals, no attempt had been made to ascertain for outpatients the recipients' share of cost. At the other hospital, information about outpatients' share of cost had been obtained when initial medical assistance was provided; however, there was no provision for updating this information. As a result,

changes in recipients' share of cost were not recognized when later services were provided.

All three hospitals obtained the recipients' share of cost from the local welfare office when patients were admitted to the hospital; however, as with outpatient services, this information was not updated.

Incorrect deductions for the recipients' share of cost had been made on about 25 percent of the 312 claims which we reviewed. We asked the local welfare agency to interview 20 of the recipients for whom a share-of-cost deduction had not been made to determine whether their share of cost may have been met elsewhere. Of these recipients, 15 advised the local welfare agency that the amount of medical expenses incurred by them had been less than their share of cost, four recipients furnished information showing that their share of cost had been met, and one recipient could not be located.

Because of the manner in which the Hospital Service of Southern California maintained and filed its claims data, it was not practicable for us to obtain and analyze a sample from all claims paid for the nine county-operated hospitals during 1969. We selected the month of December 1969 for examination because all claim transactions were complete and the related data was reasonably accessible at the hospitals for oureexamination. The amount of claims processed for this month--for the three hospitals included in our sample--was in line with the amount of monthly transactions processed during the entire year for these hospitals; comparable data was not available regarding the number of claims processed.

Officials at each of the three hospitals stated that the claims-processing procedures had not changed during the year. By applying the percentage of error for the 312 claims included in our December 1969 sample to all claims submitted during 1969 by the three hospitals, we arrived at an amount of $1.6 million, which we consider to be a reasonable estimate of the amount of claims which may have been paid by Medicaid which should have been paid by the recipients.

We discussed our findings with officials of the Los Angeles County Department of Hospitals who agreed that corrective action was needed. They advised us that new procedures would be adopted to help ensure that future eligibility and share-of-cost determinations were proper.

State officials advised us that they had considered the procedures in operation at each of the hospitals to be adequate for preventing such payments. (See p. 13.) They also stated that they had not tested the controls at the hospitals operated by Los Angeles County or at the hospitals operated by the other 15 counties given similar approval but would review the procedures and controls in future State audits.

A regional official of the Social and Rehabilitation Service stated that HEW had been unaware of the agreements between the State and the counties to permit the fiscal agent to bypass routine eligibility and share-of-cost controls.

We believe that the State should make a review to determine the amount of improper payments made on the counties' past claims. Also, the responsibility for verifying recipients' eligibility and their share of cost should be vested with an organization, such as the fiscal agent or the State, that does not submit the claim. If this is not considered practicable, the State should (1) assist counties to develop procedures to ensure proper determination of recipients' eligibility and share of cost and (2) periodically evaluate the adequacy of the procedures.

In a letter dated November 13, 1970, commenting on a draft of this report, the State informed HEW that it was in the process of gathering information needed to adjust those Medicaid claims found to have been improperly paid. The State informed HEW also that, effective August 1, 1970, State Medicaid regulations were revised to provide for direct administrative control by the State over determinations of recipients' eligibility and share of cost through the creation of the Medically Needy Operations Bureau, which was auditing, on a sample basis, the share-of-cost computations made by the counties.

Claims submitted for
noninstitutional medical services

Claims for noninstitutional medical services, such as physician services and drugs, were usually paid by the California Physicians Service without assurance that the recipients had met their share of costs. As a result, amounts which should have been paid by recipients were paid by Medicaid.

We selected, on a random basis, 137 of about 28,000 claims paid in October 1969 by this fiscal agent on behalf of medically needy recipients residing in Los Angeles County. County welfare agency records showed that (1) six claims were for persons who were not eligible at the time the service was provided, (2) 86 claims were for recipients whose share of cost ranged from $1 to $975 a month, and (3) 45 claims were for recipients whose share of cost was zero.[1]

Our review of the 86 claims paid by the fiscal agent on behalf of recipients who were responsible for paying a part of the cost showed that (1) 19 claims were supported by Medicaid identification cards showing the recipients' share of cost and by listings showing providers of services and the incurred costs to be applied toward meeting the recipients' share of cost, (2) one claim was supported by an identification card showing a share of cost which had been deducted from the claim, and (3) documentation supporting 66 claims did not show whether the recipients' share of cost had been met. There was no support for the claims submitted for the six persons who were ineligible.

We asked the county welfare agency to interview the 66 recipients to determine whether they had met their share of cost. Following are the results of these interviews.

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[1] A recipient can have a zero share of cost when (1) he is ineligible for public assistance under one of the categorical programs (see p. 7) but has no excess income or resources to meet his medical needs or (2) he is eligible for a categorical program--and therefore has no excess income or resources--but, for one reason or another, does not desire the public assistance funds.

	Number of recipients	Amount of claims paid	Amount which should have been paid by recipient
Share of cost met	19	$1,917	-
Share of cost not met	24	3,491	$1,438
Sufficient data not available to make a determination or recipient had died, moved, or could not be located	23	2,595	-
Total	66	$8,003	$1,438

Because of the manner in which the California Physicians Service maintained and filed its claims data, it was not practicable for us to obtain and analyze a sample from all claims paid during 1969. We selected the month of October for examination because, on the basis of monthly claim volume (number and amount) and discussions with California Physicians Service officials, this month appeared to be in line with the monthly transactions during 1969. By applying the error rate for the 137 claims in our October 1969 sample to all claims paid during 1969 for medically needy recipients in Los Angeles County, we arrived at an amount of $900,000, which we consider to be a reasonable estimate of the amount of claims which may have been paid by Medicaid which should have been paid by the recipients.

In commenting on a draft of this report, the State informed HEW that, in addition to revising its control system, it recently had established the Medically Needy Operations Bureau to perform a claims-clearance function that would prevent Medicaid payments to providers for those services reported by recipients as applicable to their share of cost.

Regional officials of HEW's Social and Rehabilitation Service advised us that, in their opinion, the establishment of the special unit to deal with share-of-cost problems and revisions to the State's present control system should solve the problems identified during our review.

CITY OF BOSTON

In Massachusetts, Medicaid payments are made by the State through 43 finance centers; one such center is in Boston. The Boston finance center did not determine whether recipients had met their share of cost before payments to providers were made, except for Medicaid claims for nursing-home services. Further, we found that State instructions to the finance centers and to the local welfare offices did not provide specific guidance on how the share of cost of medically needy recipients should be computed and met. On the basis of our sample of claims, we estimated that the finance center made payments of about $61,500 during the 7-month period ended October 31, 1969, which should have been paid by recipients.

The regional finance center in Boston does not have a central file of recipients who are responsible for paying their share of cost. From the center's records, however, we were able to identify 848 medically needy recipients who had a share-of-cost requirement for which Medicaid claims had been paid during the 7-month period ended October 31, 1969. We sampled 109 of these 848 recipients.

Our review of the records revealed no documentation indicating that the share of cost had been met. The deputy administrator of the regional finance center advised us that there were no procedures to ensure that the share of cost was met. At our request, the finance center mailed letters of inquiry to the 109 recipients in our sample, requesting that they advise us of the medical expenses met through their resources during those months in which Medicaid payments had been made on their behalf and that copies of the medical bills be forwarded to us. Replies were received from 91 recipients; the other 18 recipients could not be located by mail or by the regional finance center representatives.

Our review of the replies showed that 58 Medicaid recipients had not paid any of their share of cost of $15,617 and that 33 recipients had paid only $961 of their share of cost of $4,708.

Since State instructions did not provide specific guidance on how the recipients' share of cost should be administered, we requested the Department of Public Welfare to inquire into the methods used by 24 of its local welfare offices in administering the recipients' share of cost. Two offices replied that they did not have any procedures for administering the recipients' share of cost; the remaining offices described various procedures which were used to administer the recipients' share of cost.

State officials advised us that action would be taken to establish procedures to administer the recipients' share of cost.

COOK COUNTY

In September 1969 there were 18,426 medically needy cases on State rolls in Cook County. Of this total, 11,582 were shown as having insufficient income and resources and were not required to share in their medical expenses; the remaining 6,844 had a share-of-cost obligation.

Of those having a share of cost, 557 cases involved noninstitutional care, 133 involved primarily hospital care, and 6,154 involved nursing-home care. The 6-month share of cost for noninstitutional care, hospital care, and nursing-home care was about $144,000, $64,000, and $2,858,000, respectively. We selected for review 74 of these cases, of which eight involved hospital care, 36 involved nursing-home care, and 30 involved noninstitutional services.

Hospital claims

The Illinois manual of instructions provides that, if a person is in a hospital at the time the determination of eligibility is made and is responsible for paying a share of the cost, he is to pay his share to the institution; the balance will then be authorized for payment by the State. The local welfare agency is to notify both the recipient and the hospital of the share of cost to be paid by the recipient.

For five of the eight hospital cases reviewed, $17,721 that should have been paid by the recipients was paid by Medicaid, during eligibility periods encompassing up to 18 months, because, for the most part, the local welfare agency did not furnish the hospital with correct share-of-cost information. However, in some cases, the hospitals did not deduct from the bills submitted to the State the recipients' share of cost as reported to the hospitals by the local welfare agency.

We found that the State had relied entirely on the hospitals to ensure that the recipients' share of cost had been deducted from claims before they were submitted to the State for payment. The State had not established controls to verify that proper deductions had been made from the claims

before they were submitted. We also noted that the form used by the local welfare agency to notify the hospitals of the recipients' share of cost did not provide for the hospitals to deduct the share of cost from their billings to Medicaid unless payments had actually been made by the recipients.

We recognize that our findings in Cook County are not necessarily representative of the entire State; however, we believe that the State should review hospital claims to determine whether proper share-of-cost deductions have been made. Also, the form used to notify the hospitals of the recipients' share of cost should be revised to provide for deductions of the share of cost from the Medicaid claims whether or not they have been paid by recipients as is done for nursing-home claims. (See below.)

The director of the Illinois Department of Public Aid advised us that a review would be made of the other hospital claims for medically needy persons to identify cases where recipients had not met their share of cost and that, where appropriate, reimbursements would be sought. Also, State officials advised us that they would consider revising the hospital notification form and establishing controls to verify that the proper deductions for recipients' share of cost were made from hospital bills prior to payments by the State.

Nursing-home claims

Our review showed that, in most cases involving nursing-home claims, procedures for administering the share of cost were adequate. As in the case of hospitals, the Illinois manual of instructions provides that persons receiving nursing-home care pay their share of cost to the institutions. The local welfare agency notifies the nursing homes of the recipients' eligibility and share of cost. Unlike hospitals, nursing homes are required to deduct the share of cost from the claims before submitting them to Medicaid. The 6-month share of cost is prorated on a monthly basis so that the nursing homes deduct one sixth of the recipients' share from each monthly claim submitted. Before paying the claims, the State verifies that the recipients' share of cost has been deducted.

We sampled 36 claims involving nursing-home care for persons whose share of cost for 6 months totaled $40,777. Since the share of cost was prorated on a monthly basis, we examined all claims paid for a 6-month share-of-cost period, or a total of 164 nursing-home claims. We found that the nursing homes had been correctly notified by the local welfare agency of each recipient's monthly share of cost and that the nursing homes had made the proper deductions for 143 of the claims examined. The remaining 21 claims involved improper payments totaling about $725. These payments were made because (1) for 16 claims, the local welfare agency furnished incorrect share-of-cost information to the nursing homes and to the State and (2) for five claims, the nursing homes did not deduct the recipients' share of cost as shown in the notification from the local welfare agency and the errors were not detected by the State.

Noninstitutional claims

State Medicaid instructions state that, if the recipient is primarily in need of noninstitutional services (physician services, drugs, or other medical care outside a hospital or nursing home) and has a share-of-cost obligation, he is to pay the share of cost monthly into an account established by the collection unit of the local welfare agency. In turn, the State will pay all of the recipient's medical bills.

State records showed that there were 557 noninstitutional cases in Cook County and that the share of cost for these cases totaled $144,000. Collection accounts had been established for 47 of these cases; their share of cost totaled $6,300. We selected for review 30 cases from the remaining 510 for which collection accounts had not been established.

We found that collection accounts should have been established for 17 of the 30 cases and that, as a result of their not having been established, claims of $1,188 had been paid by Medicaid which should have been paid by the recipients. The accounts had not been established principally for the reason that the caseworkers had not advised the collection unit that the recipient had a share-of-cost obligation. For the remaining 13 cases, we found that, although State records indicated that recipients had a share-of-cost obligation, the

recipients did not have such obligations. The State records were incorrect because the local welfare agency had failed to advise the State of subsequent changes to the recipients' share of cost or had incorrectly computed the share of cost reported to the State.

HEW ASSISTANCE TO STATES CONCERNING RECIPIENTS' SHARE OF COST

The extent of assistance furnished to the States by regional officials of the Social and Rehabilitation Service generally has been limited to that of a liaison between the State and the Service's headquarters. The regional officials have been able to provide only limited assistance to the States in administering these Medicaid programs, and little of this assistance has involved the share-of-cost aspects of the program.

Although Program Review and Evaluation Project reviews were conducted jointly by HEW headquarters and regional office staff in California, Illinois, and Massachusetts, these reviews were of limited scope and duration. The share-of-cost aspects of the program were not covered in reviews in Illinois and Massachusetts and were only briefly mentioned in a review in California. We noted the following comments, however, in an HEW headquarters staff report on review work done in seven States, including Illinois and Massachusetts.

> "The application of any excess income of medically needy persons is such a complicated and unproductive task administratively that the States visited have given it low priority. They do attempt to apply it for institutional care, but not for ambulatory care ***."

The HEW regional officials, however, had not provided any assistance to the State to solve the administrative problems which existed.

In HEW's Chicago Regional Office (responsible for five States), the staff assigned to the Medicaid program consisted of only two persons. In both California (responsible for seven States plus Guam) and Massachusetts (responsible for six States), there were three persons assigned to Medicaid activities. Regional officials advised us that limited staffing had prevented them from giving greater assistance to the States and that they had to rely upon the States to review and evaluate Medicaid activities. We noted that an HEW Audit Agency report dated August 26, 1969, on audits in 16 States pointed out that regional office staff assigned to Medicaid usually consisted of two professionals who made

limited program evaluations and surveillance, if they made any at all.

CONCLUSIONS

California, Illinois, and Massachusetts have encountered difficulties in administering the recipients' share-of-cost aspect of the Medicaid program. As a result, Medicaid has paid for medical services which should have been paid for by recipients. We believe that strengthening existing procedures pertaining to identifying and accounting for recipients' share of cost or instituting such procedures where none are in force would significantly reduce this problem.

Although officials in each State generally agreed with our findings, they stated that the complexity of share-of-cost determinations made the relative value of trying to monitor the administration of the share of cost questionable except in cases in which significant amounts were involved or in which controls could be easily applied (such as when recipients were in hospitals or nursing homes).

RECOMMENDATIONS TO THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE

We recommend that the Secretary of Health, Education, and Welfare have the Social and Rehabilitation Service evaluate the systems of control in existence in the 27 States which currently include medically needy persons under their Medicaid programs to identify those procedures which appear most effective for ensuring that the recipients' share of cost is met for both institutional and noninstitutional services. After identifying these procedures, the Service should either (1) disseminate the information to the States with the recommendation that the procedures be followed or (2) develop a model system for use by the States.

We recommend also that the Secretary have the Social and Rehabilitation Service--as part of the above evaluation--consider the practicability of controlling the administration of the recipients' share of cost in cases in which the amount is small or the required controls are burdensome. If it is determined that the administration of the existing

share-of-cost aspect of the program cannot be made practicable, the Service should consider alternative approaches to cost sharing. For example, one approach suggested in the Senate Committee on Finance staff report on "Medicare and Medicaid, Problems, Issues, and Alternatives" issued on February 9, 1970, was to revise title XIX to allow States to use a method of obtaining a share of cost from a recipient which would not be entirely dependent on the recipient's income and resources. House bill 1, introduced on January 22, 1971, to amend the Social Security Act contains a stipulation which would permit States to apply copayment provisions to claims of medically needy persons, which are not related to income.

We recommend further that the Secretary seek appropriate adjustments for past improper payments charged to Medicaid because of failure of those county-operated hospitals in California to verify eligibility or to deduct the recipients' share of cost from Medicaid claims.

AGENCY COMMENTS AND ACTIONS

By letter dated March 11, 1971, the Assistant Secretary, Comptroller, HEW, furnished us with HEW comments on our findings and recommendations. (See app. I.)

HEW agreed with our recommendation that the Service evaluate the systems of control in existence in the 27 States which currently include medically needy persons under their Medicaid programs to identify those procedures which appear most effective for ensuring that the recipients' share of cost is met for both institutional and noninstitutional services.

HEW informed us that it was reviewing the procedures used in all 27 States that cover the medically needy to ensure that (1) recipients' incomes are properly taken into account in paying medical bills and making claims for the Federal share of such bills and (2) payments for medical services that are not subject to Federal sharing are excluded from the claims. HEW stated that, when the results of these efforts were sufficient to make a reasonable evaluation, it expected to develop a joint plan of action by the several units in HEW that would need to be involved.

HEW informed us also that the plan of action and the consideration of alternatives would take into account the effect and impact that any congressional action on proposed legislative changes would have on program operations. HEW stated that, in the meantime, it was pursuing the matter of corrective action when HEW reviews indicated that the procedures in an individual State were ineffective.

HEW agreed with our recommendation that it seek appropriate adjustments for past improper payments caused by failure of those county-operated hospital in California to verify eligibility or to deduct the recipients' share of cost from Medicaid claims. HEW informed us that the State had promised to adjust improperly paid Medicaid claims and that HEW would follow up on the action promised by the State.

Concerning the discussion on pages 25 and 26 relating to the limited HEW staff available to assist the States in administering the Medicaid program, HEW stated that, although some increases had been made, the staff was still inadequate for in-depth surveillance of State and local operations, particularly in the fiscal area. HEW stated that the staffing problems were, in larger part, due to a scarcity of employees qualified in medical care administration and expressed the hope that the authority provided by the enactment on January 5, 1971, of the Intergovernmental Personnel Act of 1970 would assist in solving problem.

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We believe that the actions taken and promised by HEW will help to improve the effectiveness of controls over recipients' share of cost.

CHAPTER 3

NEED FOR HEW TO ENSURE STATES' COMPLIANCE WITH STATUTORY LIMITATION ON FEDERAL SHARE OF MEDICAID COSTS

For States which elect to provide assistance to medically needy persons, title XIX specifies a limitation on the extent of the Federal share of the costs. This limitation is in the form of a maximum amount of annual family income for maintenance needs (food, shelter, clothing) to be used in computing the family share of cost to be applied to medical bills. States may specify income levels above the Federal maximum, but HEW's financial participation in medical assistance will be limited to the amount which would have been allowable if the Federal maximum had been used.

HEW needs to take steps to ensure that State claims for the Federal share of the costs of medical services provided to medically needy persons do not include amounts which exceed maximums specified under section 1903 (f)(1)(B)(i) of the act. We found that HEW had paid claims submitted by California for the period July 1 through December 31, 1968, for persons whose incomes exceeded the limitations set forth in the act. We noted that, although these limitations were not exceeded in Illinois and Massachusetts, HEW paid claims from seven other States where such limitations were exceeded.

Title XIX limits the annual income that States may permit medically needy families to use for maintenance needs (in computing their share of cost) to a certain percentage of the amount paid by the State to families receiving public assistance under title IV, aid to families with dependent children. The following percentages were used.

1. From July 1 to December 31, 1968, 150 percent; during 1969, 140 percent; and thereafter, 133-1/3 percent for States which had an approved-title-XIX program prior to July 26, 1967.

2. For those States whose title XIX program was approved after July 25, 1967, 133-1/3 percent.

To illustrate, for the period July 1 through December 31, 1968, under the aid to families with dependent children program, California paid a family consisting of two persons $155 a month for maintenance. Thus, under the provisions of title XIX, a medically needy family of two would have been allowed $233 (150 percent of $155) of its income for maintenance in computing its share of cost. We found, however, that California had allowed $281 monthly, or $48 more than allowed by the act. If a State chooses to use higher income levels than the maximum established using the Federal formula, HEW requires that the levels be submitted to HEW for prior approval and that procedures be established to ensure that claims for financial participation are limited to the income levels provided by law. In the illustration given, California would have had to pay 100 percent of the first $48 a month of Medicaid claims for this family.

During the period July 1 through December 31, 1968, the income levels established by California for 2- and 3-member medically needy families exceeded the Federal limitations. Claims for Federal funds were not limited to amounts which would have been paid if the Federal maximum income levels had been used, therefore some part of the State's claims during these 6 months should not have been paid by Medicaid. Since about 75,000 Medicaid claims were for 2- and 3-member families during this 6-month period, we believe that the amount of payments made by HEW which should have been made by the State was substantial.

State officials informed us that, because HEW had been delinquent in advising them of the manner in which to apply the Federal limitations, California should not be held financially responsible for the questioned payments.

HEW regional officials did not agree with the State regarding the inappropriateness of an adjustment. The Acting Regional Commissioner, Social and Rehabilitation Service, by letter dated February 20, 1970, informed the California Department of Health Care Services that an adjustment should be made for excess funds claimed from July through December 1968.

Other States also may have received incorrect payments because their established income levels for medically needy persons exceeded the Federal limitations. During the July 1968 to March 1970 period, seven other States had income levels that exceeded Federal limitations for various family-size categories. The Social and Rehabilitation Service paid claims to these States without determining whether they had implemented procedures to limit such claims to the Federal maximum. Service officials advised us that the HEW Audit Agency had not examined into this aspect of the States' Medicaid programs.

The States with income standards in excess of the Federal maximums, including the family size and the amounts involved for the applicable periods, are listed in appendix III.

In a letter dated March 17, 1970, we requested that the Administrator of the Social and Rehabilitation Service (1) examine into the extent to which Federal funds in excess of authorized amounts may have been paid to the eight States and effect adjustments where appropriate and (2) ensure that procedures are adequate to exclude from future Federal claims amounts which should be paid by the States.

The Administrator, in a letter of instruction dated May 18, 1970, to the Regional Commissioners, directed that reviews be made of this matter. As indicated on page 28, HEW informed us that it was in the process of taking actions aimed at correcting past improper payments.

CONCLUSION

HEW needs to establish procedures to ensure that States' claims for the Federal share of the costs of medical services provided to medically needy families do not include amounts which exceed maximums specified under section 1903 (f)(1)(B)(i) of the act.

RECOMMENDATION TO THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE

In view of the corrective action now under way, we are not making any recommendations relating to adjustments required for past payments.

We are recommending, however, that the Secretary of Health, Education, and Welfare have the Social and Rehabilitation Service, whenever it approves State income levels in excess of the 133-1/3-percent criterion, require that follow-up action be taken by regional officials to ensure compliance with the statutory limitation.

AGENCY COMMENTS AND ACTIONS

In commenting on the above recommendation (see app. I), HEW stated that it had emphasized to all regions the need for regional officials to take follow-up action to ensure compliance with the statutory limitation when State income levels in excess of the 133-1/3-percent criterion were approved. HEW stated that it planned to determine whether appropriate action had been taken in such instances.

HEW stated also that the Social and Rehabilitation Service was reviewing the control procedures in California and the other seven States that had income levels for the medically needy in excess of the statutory limitation. HEW stated further that it was pursuing the matter of adjustments for those States which had not established procedures for excluding ineligible costs from their claims for Medicaid funds.

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We believe that the actions taken and promised by HEW will help to obtain compliance with the statutory limitation on the amount of recipients' incomes to be considered in determining their share of cost and in claiming Medicaid funds.

CHAPTER 4

IMPROVEMENTS NEEDED IN QUALITY CONTROL REVIEWS

Our review showed that the quality control review systems--which for title XIX are means of controlling the level of ineligibility and/or incorrect share-of-cost computations--in California and Massachusetts had been ineffective.

The HEW Handbook of Public Assistance Administration requires that a quality control system be used by the States in administering the Medicaid program. At the time of our fieldwork, the system's basic objective was to provide a systematic and continuous control by the State agency over the correctness of decisions reached by local welfare agencies, including those pertaining to eligibility. The system encompassed (1) reviewing continuously samples of local agency actions, (2) assembling and analyzing the findings, (3) planning and carrying out corrective measures to deal with problem areas as they come to the State agency's attention, and (4) reporting periodically to HEW on the results of the reviews.

Quality control data in California had not been tabulated, analyzed, or reported to HEW, and, as a result, causes of significant problems relating to share-of-cost determinations had not been identified. In Massachusetts quality control reviews were not made from April 1968 to July 1969. During this period HEW and the State had no assurance that eligibility and share-of-cost determinations being made by individual caseworkers were correct. In Illinois the effectiveness of the quality control system was reduced because the minimum number of cases required by HEW had not been sampled.

HEW requires the States to submit annually reports on the results of their reviews. The first quality control reports for Medicaid were to have been submitted on June 30, 1969, and were to have covered the 12-month period April 1, 1968, through March 31, 1969. The second report was to have covered the period July 1, 1969, through June 30, 1970. HEW suspended quality control requirements for all States during the period April 1, 1969, through June 30, 1969, because of its plan to introduce a revised system on July 1,

1969. HEW later changed its plan, however, and the existing system was resumed on July 1, 1969. On October 1, 1970, HEW directed all States to implement a revised quality control system.

The revised system provides for a continuous review of statistically reliable, statewide samples of cases and emphasizes the implementation of corrective measures to deal with problems that have been identified. As of March 11, 1971, California had not fully implemented HEW's quality control system.

NEED FOR TIMELY ANALYSIS AND REPORTING IN CALIFORNIA

As of June 1970, California had not submitted its required annual report for the period ended March 31, 1969. State officials informed us that the required number of reviews had been made but that the data had not been analyzed because of staffing limitations.

The HEW Audit Agency in a report dated June 25, 1969, commented on the State's need to tabulate and analyze the review results. The HEW Audit Agency's analysis of the data accumulated by the State showed that errors had been made by caseworkers in determining the recipients' share of cost in 17 percent of the cases sampled by the State. These errors were made because of the local welfare staff's incorrect computations and incorrect application of the Service's regulations. In some cases the errors were caused by the recipients' misstating their incomes and resources at the time they applied for Medicaid.

In commenting on the HEW Audit Agency's findings, the State, in a letter dated July 25, 1969, to the Regional Commissioner of the Social and Rehabilitation Service, stated that it was working on improving its quality control system so that a higher level of surveillance could be maintained. In June 1970 State officials advised us, however, that insufficient staffing continued to limit the effective implementation of the quality control system.

The Audit Agency's findings demonstrate the need for the timely analysis and reporting of the results of quality

control reviews. Because the State had not analyzed the results of its reviews at the completion of our fieldwork, one of the primary purposes of the quality control system--the planning and implementation of corrective measures to deal with significant problem areas--had not been achieved. As of May 1971, California still had not submitted its annual report for the period ended March 31, 1969.

Recommendation to the Secretary of Health, Education, and Welfare

We recommend that the Secretary of Health, Education, and Welfare have the regional office review the action taken by California to improve its quality control system, including the impact of the State's staffing problems on achieving the desired results of quality control.

Agency comments and actions

In commenting on the above recommendation (see app. I), HEW stated that the implementation of the new Federal quality control system beginning October 1, 1970, included plans for monitoring and reviewing State quality control operations. HEW stated also that arrangements had been made to have evaluations of the operations of some States, including California, Illinois, and Massachusetts, made under contract.

QUALITY CONTROL PROGRAM DELAYED IN MASSACHUSETTS

Quality control reviews were to be initiated by the State on April 1, 1968. These reviews, however, were not initiated by Massachusetts until July 1, 1969. During this period $286 million was expended by the State for medical assistance furnished to its medically needy. HEW approved the State's request dated December 18, 1967, to delay implementation of a quality control system because of a reorganization of the State's public welfare system.

Prior to July 1, 1968, the public assistance programs were operated by local public welfare offices which were individually responsible for administration of the programs in their locales. Effective July 1, 1968, the administrative

responsibility was placed with a single State organization comprising the 270 local offices. According to the State, the use of the quality control staff was essential to accomplish the reorganization; thus the quality control staff would not have been able to carry out its normal duties.

HEW approved the State's request with the understanding that quality control reviews would be resumed on September 1, 1968, and would include a larger sample of cases than that normally required. The State, however, was unable to resume the reviews, contrary to its agreement. After several months of correspondence between the HEW regional office and the HEW headquarters regarding the State's delay in implementing a quality control system, HEW decided in January 1969 that, in view of the ongoing difficulties in the welfare reorganization, the State would be exempted from making quality control reviews until July 1, 1969.

On July 1, 1969, Massachusetts resumed its quality control program for fiscal year 1970. At the completion of our fieldwork in June 1970, however, we noted that the State had reviewed only 280 (or about 64 percent) of the 439 cases selected for quality control review.

Recommendation to the Secretary of Health, Education, and Welfare

We recommend, therefore, that the Secretary of Health, Education, and Welfare have the regional office closely monitor the progress of Massachusetts in meeting its quality control objectives and provide the necessary assistance to ensure that the State's quality control system is effective.

Agency comments and actions

In commenting on the above recommendation (see app. I), HEW stated that, with added staff and the new quality control system, the objectives should be obtained.

MINIMUM SAMPLE NOT REVIEWED IN ILLINOIS

Quality control reviews in Illinois were initiated on April 1, 1968, as required by HEW. The number of cases reviewed by the State, however, during the 12-month period

April 1, 1968, through March 31, 1969, was considerably less than the minimum number of cases specified for review by HEW.

HEW initially specified a minimum annual sample size for Illinois of 450 cases but subsequently reduced the size for States, such as Illinois, that were experimenting with new eligibility determination methods. For Illinois the minimum annual sample size was reduced to 335 cases.

For the period April 1, 1968, to September 30, 1968, Illinois complied with the initial HEW sample size and, beginning October 1, 1968, implemented the revised sample size for the second 6 months of the annual reporting period. Consequently, the minimum sample size as prorated for the 12-month reporting period was 392 cases.

The State's objective was to select 408 cases, slightly more than the minimum number required by HEW. However, the number of cases reviewed, 328, was less than the minimum sample size required by HEW.

The specified sample size was not achieved because some of the cases selected involved persons who had subsequently died or moved or who could not be located. Some of the cases selected did not represent new eligibility and share-of-cost determinations, but they were reported as such by the counties to the State although they involved only changes of address or some other administrative action.

State officials informed us that they did not consider the underrun in the cases sampled to be significant. HEW officials advised us that the minimum sample size would be increased substantially beginning October 1970 and that the problem of inadequate sample size should be corrected.

Recommendation to the Secretary of Health, Education, and Welfare

We recommend that, to determine whether an adequate number of cases are reviewed, the Secretary of Health, Education, and Welfare have the State's progress in attaining the expanded quality control sample size monitored.

Agency comments and actions

In commenting on the above recommendation (see app. I), HEW stated that the new quality control system provided for a substantially increased sample size and that HEW's initial evaluation plans were aimed at evaluating the effectiveness of the new system in achieving the desired results.

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We believe that the actions taken and promised by HEW will help to improve quality control reviews.

APPENDIXES

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

OFFICE OF THE SECRETARY

MAR 11 1971

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

Dear Mr. Heller:

The Secretary has asked me to respond to the draft report on the GAO review of "Ineffective Controls Over Program Requirements Relating to Medically Needy Persons Covered by the Medicaid Program." Enclosed are the Department's comments on the findings and recommendations in your report.

We appreciate this opportunity to comment prior to the issuance of the final report.

Sincerely yours,

James B. Cardwell
Assistant Secretary, Comptroller

Enclosure

Comments on GAO Draft Report on
"Ineffective Controls Over Program
Requirements Relating to Medically
Needy Persons Covered by the Medicaid
Program"

The Department is in general agreement with the conclusions and recommendations in this report. The GAO recommendations and the Department's response to each are summarized below.

Copies of the comments on the draft report received from each of the California agencies (Medicaid and Social Welfare) are attached. The Massachusetts agency initiated corrective action as soon as the problems were revealed during the course of the review; they had no further comments on the draft report. The comments received from Illinois to date did not pertain to the substantive matters discussed in this report.

In addition we have noted two points in the findings which also merit comments.

1. We noted (page 7 of the draft report) the widely differing policies among the States as to allowances for work related expenses. We have reviewed the policies in other States and clarification of income disregard policies as applicable to Title XIX is in process.

2. We noted the findings (pp. 23-24 of the draft report) as to limited staff in SRS available to assist the States in administering the Medicaid programs. While some staff has been added, we concur that the staff is still inadequate for in-depth surveillance of State and local operations, particularly in the fiscal area. Both the Federal and State problems are in a large part due to the scarcity of personnel qualified in these aspects of medical care administration. We hope that the authority provided by the enactment of Public Law 91-648 on January 5, 1971, the "Intergovernmental Personnel Act of 1970," will assist in resolving this problem.

Recommendations under "Controls Over Recipients' Share of Cost" (page 25 of draft report)

1. "We recommend that the Social and Rehabilitation Service evaluate the systems of control in existence in the 28 States which currently have medically needy programs to identify those procedures which appear most effective in ensuring that the share of cost is met by the recipient for both institutional services and non-institutional services."

Response

Pursuant to an earlier inquiry by the GAO, the Social and Rehabilitation Service requested the regions on May 18, 1970, to review and report on the procedures used in all 28 States that

cover the medically needy to assure that the recipient's income is properly taken into account in paying medical bills and claiming Federal financial participation. We also asked the regions to review the controls used to assure that other medical payments properly made under the State plan, but not subject to Federal financial participation, are excluded from the Federal claim.

Because priority in these reviews was to be given to reviews in the States that had income levels in excess of the limitation in the Federal law, because of inadequate regional staffing, and because of regional reorganization, reports on less than half of the 28 States have been completed.

When sufficient input has been received to make a reasonable evaluation, we expect to develop a joint plan of action with participation by the several units in SRS and the Department that will need to be involved.

At that time consideration will be given to the further recommendations in the draft report as follows:

a. "After identification of the State procedures which appear most effective, SRS should either (1) disseminate the information to the States with the recommendation that they be put into practice or (2) develop a model system for use by the States."

b. "In view of the concern expressed relating to the relative value of controlling the share of cost where the amount is small or where the required controls are burdensome--give consideration to the practicality of controlling the share of cost under such circumstances. If it is determined that the administration of the present share of cost aspect of the program cannot be made practicable, consideration should be given to alternative approaches to cost sharing by the medically needy." (such as changes in the law).

The plan of action and the consideration of alternatives will, of course, have to take into account the effect and impact on Federal and State operations of presently proposed changes in the law now being considered by the Congress.

In the meantime however the Department is pursuing the matter of corrective action in individual State situations where these reviews indicate that procedures are ineffective.

2. "We recommend further that HEW seek appropriate adjustments for past overclaims caused by those county-operated hospitals in California which failed to verify eligibility or to deduct the share of cost from Medicaid claims."

Response

The comments on the draft report dated 11/13/70 submitted by the California Department of Health Care Services states "The Department is currently in the process of gathering information needed to adjust those county Medicaid claims that are found to have been incorrectly paid."

If this adjustment does not appear in the California agency's next expenditure statement, the Department will follow-up.

Recommendations under "Need for HEW to Assure Compliance with Statutory Limitation in Claiming Federal Funds) (page 30 of draft report)

3. "HEW needs to establish procedures to assure that States' claims for Federal sharing of costs do not include amounts paid for services to medically needy families which exceed maximums specified under Section 1903(f)(1)(B)(i) of the act. ... So long as limitations on income levels exist in determining the Federal share of Medicaid expenses, we recommend that whenever the SRS approves States' income levels in excess of the present 133 1/3% criteria, follow-up action be taken by the regional office officials to assure compliance with the statutory limitation."

Response

As indicated in the report, the SRS is reviewing the control procedures in the seven other states that have or have had income levels for the medically needy in excess of the statutory limitation, and we are pursuing the matter of adjustments by States which failed to establish procedures for excluding non-matchable payments from the Federal claim.

In regard to future instances when State income levels in excess of the 133 1/3% criteria are approved, our request to all regions to review and report on the State procedures in this entire subject area has effectively emphasized the need for regional officials to take follow-up action. When the central office is informed that a State has changed its AFDC payment level, we plan to check whether appropriate action has been taken in regard to the income levels for medically needy eligibility.

Recommendations under "Improvements Needed in Quality Control Reviews".

4.a. "We recommend that the HEW Regional Office review the action taken by the State (California) to improve its quality control system

including the impact of the State's staffing problems in achieving the desired results of quality control." (p. 33)

b. "We recommend that the HEW Regional Office closely monitor the progress of Massachusetts in meeting its quality control objectives and provide necessary assistance to ensure that an effective system is being carried out." (p. 34)

c. "We believe that HEW should evaluate future State sample size selection plans to determine whether an adequate number of cases are reviewed. We recommend therefore, that HEW monitor the State's (Illinois) progress in attaining the expanded quality control goals." (p. 36)

Response

4.a. The comments by the California Department of Social Welfare on the draft report (letter dated October 30, 1970) reports the progress made by the State despite insufficient staff.

The implementation of the new Federal quality control system beginning October 1, 1970, includes plans for monitoring and review of State quality control operations. Pending the availability of sufficient Federal staff for this purpose, arrangements have been made to have some of this evaluation done by contract. (California, Illinois, and Massachusetts are included in these contracts).

b. The response of the regional office to this recommendation indicates that with added staff and the new quality control system the objectives should be obtained.

c. As indicated in the report, the new quality control system beginning October 1970 calls for a substantially increased sample size. The initial evaluation plans are directed more to evaluating the effectiveness of the system itself in achieving the desired results rather than how well the State is implementing it. The adequacy of the sampling plan, will of course be an essential aspect of this evaluation.

EXAMPLE ILLUSTRATING COMPUTATION OF RECIPIENTS' SHARE OF COST IN CALIFORNIA, ILLINOIS, AND MASSACHUSETTS

The following example is used to illustrate how a recipient's share of cost would have been computed in California, Illinois, or Massachusetts at the time of our fieldwork.

> A medically needy family consisting of a working mother with two children who earns $550 monthly after taxes. Payments are $50 a month on a car which the mother drives 30 miles a day (round trip) to work. Day care for the children costs $200 a month. She owns a home valued at $18,000 and other personal property valued at $700. One child required hospitalization and medical treatment for 2 weeks which resulted in medical expenses of $800.

In computing the amount of excess resources, this family would have been allowed to exclude property valued up to $3,000 in California, $700 in Illinois, and $3,100 in Massachusetts. In each of the three States, the home, car, and household furnishings would have been excluded. The table below shows the adjustments to income which would have been allowed and the recipient's share of cost which would have been computed in each of the three States.

	California	Illinois		Massachusetts
		Assumption A	Assumption B	
Monthly earnings after taxes	$550	$550	$ 550	$550
Less work-related adjustments and allowances:				
Work-related expenses including transportation and child care	299	-	-	11
Gross earnings exclusion (note a)	203	203	-	-
Basic maintenance allowance	233	250	250	292
Total adjustments and allowances	735	453	250	303
Total monthly excess	$ -	$ 97	$ 300	$247
Recipients' share of cost (note b)	$ -	$582	$1,800	$247

[a] To simplify the computation, we have used monthly earnings after taxes rather than gross earnings as our computation base. Therefore, differences in State income taxes are not considered in our computation which is presented for illustrative purposes.

[b] Recipients' share of cost for Illinois is on a 6-month basis.

Explanations of the computations follow.

Work-related expenses--A flat deduction of $11 was allowed for all work-related expenses in Massachusetts; no other deductions from earned income after taxes were provided. California allowed (1) 4 cents a mile for transportation and up to $75 a month for car payments, (2) child-care payments up to a maximum of $25 a week for each child, and (3) a standard $25-a-month deduction for the additional costs of food, clothing, and other personal incidentals related to employment. Illinois does not allow any deduction for work-related expenses.

Gross earnings exclusion--California allowed a deduction of the first $30 plus one third of the remainder of the monthly earnings for families with dependent children. In Illinois, if the mother had received assistance during one of the 4 preceding months, the family would have been eligible for the gross earnings exclusion (assumption A). However, if the mother had not received assistance during one of the 4 preceding months, the family would not have been eligible for the gross earnings exclusion (assumption B). In Massachusetts no exclusion was allowed.

Basic maintenance allowance--The amounts deducted were specified in the respective State plans. The amounts represent the income protected for daily living expenses other than medical care.

Recipient's share of cost--In California a medically needy person with monthly excess income was expected to devote only 1 month's excess income to his medical expenses in any given month. In Illinois, however, the excess income for the month in which medical expenses were incurred plus the following 5 months was considered as available to meet current medical expenses. In Massachusetts only 1 month's excess income was considered available, until recently. Massachusetts changed its State plan to require that the recipients' excess income for 6 months be considered, as is done in Illinois. Since the change had not been implemented at the completion of our fieldwork, our computation for Massachusetts was based on the 1-month criterion; had the 6-month period been considered, the recipient's share of cost would have been $1,482 in this example.

Subsequent to the completion of our fieldwork, we were advised of changes in the California regulations, effective August 1, 1970. These changes include:

1. The establishment of property limits which, if exceeded, would result in exclusion of the recipient from the program. The personal property limits established will range from $1,200 for one person to $2,000 for a family of nine or more. The real property limit has been set at $5,000 in assessed valuations (exclusive of the home in which the recipient lives).

2. The consideration of resources available to a recipient over 3 calendar months in establishing the share of cost for other than long-term-care patients. Long-term-care patients' share of cost will continue to be computed on a monthly basis.

STATES WITH ANNUAL INCOME STANDARDS

IN EXCESS OF THE FEDERAL MAXIMUMS

State	July 1, 1968, through June 30, 1969			After June 30, 1969		
	Family size	Federal maximum	State standard	Family size	Federal maximum	State standard
California	2	$2,700	$3,372		$ -	$ -
	3	3,100	3,636			
Connecticut				2	3,000	3,200
Delaware	1	1,400	1,500	1	1,300	1,500
	5	3,600	3,800	4	3,200	3,300
				5	3,400	3,800
	6	3,800	4,300	6	3,600	4,300
	7	4,000	4,800	7	3,800	4,800
	8	4,200	5,200	8	3,900	5,200
	9	4,400	5,600	9	4,100	5,600
	10	4,500	6,000	10	4,200	6,000
Kentucky				1	1,200	1,620
				2	1,900	2,200
				3	2,600	2,820
				4	3,200	3,420
				5	3,700	4,020
				6	4,000	4,500
				7	4,500	4,980
				8	4,600	5,340
				9	5,100	5,700
				10	5,500	6,060
New Hampshire				1	2,000	2,088
Oklahoma	1	1,600	1,728	1	1,400	1,728
Pennsylvania	1	1,900	2,000			
Maryland:						
Plan A	1	1,600	1,800	1	1,600	1,800
				2	2,200	2,280
Plan B	1	1,600	1,800	1	1,600	1,800
	2	2,200	2,280	2	2,100	2,280
				6	3,900	3,960
				7	4,300	4,380
				9	5,200	5,220

APPENDIX IV

LISTING OF OTHER GAO REPORTS

ISSUED TO THE CONGRESS ON THE MEDICAID PROGRAM

	Date issued
Questionable claims under the Medicaid program for the care of persons in State institutions for the mentally retarded in California	May 11, 1970
Problems in approving and paying for nursing-home care under the Medicaid program in California	July 23, 1970
Continuing problems in providing nursing-home care and prescribed drugs under the Medicaid program in California	Aug. 26, 1970
Improvement needed in the administration of the Iowa and Kansas Medicaid programs by the fiscal agents	Oct. 20, 1970
Controls over Medicaid drug program in Ohio need improvement	Nov. 23, 1970
Ways to reduce payments for physician and X-ray services to nursing-home patients under Medicare and Medicaid	Feb. 2, 1971
Control needed over excessive use of physician services provided under the Medicaid program in Kentucky	Feb. 3, 1971
Problems in providing proper care to Medicaid and Medicare patients in skilled nursing homes	May 28, 1971

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

	Tenure of office	
	From	To
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 REHABILITATION SERVICE:		
John D. Twiname	Mar. 1970	Present
Mary E. Switzer	Aug. 1967	Mar. 1970

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