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02224 - [A1332328] (~~Restricted~~)

Lack of Coordination between Medicaid and Medicare at John J. Kane Hospital. HRD-77-44; B-164031(3). May 6, 1977. 44 pp.

Report to Sen. Frank Church, Chairman, Senate Special Committee on Aging; by Elmer B. Staats, Comptroller General.

Issue Area: Health Programs: Compliance With Financing Laws and Regulations (1207).
Contact: Human Resources and Development Div.
Budget Function: Health: General Health Financing Assistance (555); Health: Nursing Homes (557).
Organization Concerned: Department of Health, Education, and Welfare; Health Care Financing Administration; John J. Kane Hospital, Pittsburgh, PA.
Congressional Relevance: Senate Special Committee on Aging.
Authority: Social Security Act, title XIX. Social Security Act, title XVIII. 45 C.F.R. 250.30(a)(8). 45 C.F.R. 248.3(b).

Management practices of the John J. Kane Hospital which were reviewed included the management of patients' funds, cost reporting for Medicaid in 1974, staffing procedures, and the practice of crediting the Medicaid program for contributions from relatives of patients. Findings/Conclusions: Medicaid and Medicare programs at the hospital were not coordinated. Problems caused by this lack of coordination included: patients paid for services covered by either or both programs; the hospital incorrectly charged the costs of some services to both programs; State Medicaid program rules violated Federal regulations; and audit information was not exchanged between Medicaid and Medicare. Additional problems were identified in the hospital's staffing practices and solicitations of contributions from relatives of the patients. Recommendations: The Secretary of Health, Education, and Welfare should require the Administrator of the Health Care Financing Administration to direct the State to: amend its state plan and regulations; make sure that Kane Hospital patients get the required quarterly accounting of their personal needs accounts; and insure that the hospital gets proper authorizations of expenditures from their accounts. He should: require the State, Kane Hospital, and other providers of services to the hospital's patients to follow proper Medicaid billing procedures; assure that money earned through the investment of patients' funds is fairly distributed; direct the State to recompute the Federal share of the Medicaid payments; recover the Federal share of Medicaid overpayments to the hospital; and provide for the exchange of audit information between the Medicare intermediary and the State Auditor General. (Author/SC)

*REPORT TO THE SENATE SPECIAL COMMITTEE ON AGING*

*BY THE COMPTROLLER GENERAL OF THE UNITED STATES*

# Lack Of Coordination Between Medicaid And Medicare At John J. Kane Hospital

Health Care Financing Administration
Department of Health, Education, and Welfare

Medicare and Medicaid programs at John J. Kane Hospital, Allegheny County, Pennsylvania, were not coordinated, causing several problems:

--Patients paid for services covered by either or both programs.

--Kane Hospital incorrectly charged the costs of some services to both programs.

--State Medicaid program rules violated Federal regulations.

--Audit information was not exchanged between Medicare and Medicaid.

Additional problems were identified in Kane Hospital's staffing practices and solicitation of contributions from relatives of patients.

HRD-77-44

MAY 6, 1977

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

B-164031(3)

The Honorable Frank Church
Chairman, Special Committee
on Aging
United States Senate

Dear Mr. Chairman:

In response to the request of your former Subcommittee on Long-Term Care, this report reviews selected aspects of the management of John J. Kane Hospital, a county nursing home in Pittsburgh, Pennsylvania.

We identified management weaknesses at Kane Hospital as well as instances in which Pennsylvania's management of its Medicaid program conflicted with Federal requirements. We also found coordination of benefit payments under Medicare and Medicaid lacking at Kane Hospital. Comments on a draft of this report by Kane Hospital; the State of Pennsylvania; and the Department of Health, Education, and Welfare are included.

This report contains recommendations to the Secretary of Health, Education, and Welfare. As you know, section 236 of the Legislative Reorganization Act of 1970 requires the head of a Federal agency to submit a written statement on the actions taken on our recommendations to the House Committee on Government Operations and the Senate Committee on Governmental Affairs not later than 60 days after the date of the report and the House and Senate Committees on Appropriations with the agency's first request for appropriations made more than 60 days after the date of the report. We will be in touch with your office in the near future to arrange for release of the report so the requirements of section 236 can be set in motion.

Sincerely yours,

Comptroller General
of the United States

COMPTROLLER GENERAL'S
REPORT TO THE SENATE
SPECIAL COMMITTEE ON AGING

# LACK OF COORDINATION BEWTEEN MEDICAID AND MEDICARE AT JOHN J. KANE HOSPITAL

Health Care Financing Administration
Department of Health, Education, and Welfare

## D I G E S T

John J. Kane Hospital--a 2,111 bed public nursing home maintained and operated by Allegheny County, Pennsylvania--furnishes skilled and intermediate nursing care, mostly to Medicaid patients. About one-fourth of Kane's beds are available for skilled nursing care under Medicare.

Medicare and Medicaid programs at John J. Kane Hospital, Allegheny County, Pennsylvania, were not coordinated, causing several problems:

--Patients paid for services covered by either or both programs.

--Kane Hospital incorrectly charged the costs of some services to both programs.

--State Medicaid program rules violated Federal regulations.

--Audit information was not exchanged between Medicare and Medicaid.

Additional problems were identified in Kane Hospital's staffing practices and solicitation of contributions from relatives of patients.

## INAPPROPRIATE USE OF PATIENTS' FUNDS

Following State regulations which were contrary to Federal regulations, Kane Hospital allowed too much money to accumulate in the personal needs accounts of its patients. This happened because patients were routinely allowed to keep in their personal accounts as much as $175 a month ($150 a month too much) during the first 6 months of their

stay at Kane Hospital. Officials at Kane estimated the excessive amount as $732,000 each year. (See p. 9.)

As a general rule, Kane Hospital was authorized to receive money on behalf of patients but neither (1) routinely gave patients the required quarterly accounting of financial transactions made for them nor (2) usually had the proper authorizations for spending patients' funds.

Kane Hospital spent patients' funds for

--medical services properly payable by the Medicare and Medicaid programs (see p. 11),

--Medicare deductible and coinsurance amounts properly payable by Medicaid (see p. 12),

--amounts above reasonable charges for medical services (see p. 14).

Erroneous payments from patients' funds for facility based physician services could have amounted to as much as $441,000 from 1972 to 1974. (See p. 21.) Similarly, patients could have paid an additional $160,000 for laboratory and X-ray services for 1972-74. The costs of these services were included in Kane's Medicaid reimbursement rates. (See p. 23.)

In addition, Kane Hospital invested otherwise idle patients' funds in interest-bearing savings certificates but had never distributed interest earnings to individual patient's accounts.

As of January 1976 these earnings amounted to $217,000. (See p. 15.)

## KANE HOSPITAL OVERCHARGED THE FEDERAL GOVERNMENT

Through a procedure by which Kane Hospital charged both Medicare Part B and Medicaid for the costs of the same services, the

Federal Government paid out more than $510,000 too much under Medicaid during 1972-74 for the services of facility-based physicians. (See p. 19.) Similarly, the Federal share of costs charged to Medicaid for the costs of X-ray and laboratory services also charged to Medicare Part B in 1972-74 was about $145,000. (See p. 22.)

An exchange of audit information between Medicare and Medicaid would have prevented these duplicate or overlapping charges.

STAFFING PRACTICES

In a review of staffing practices and related recordkeeping at Kane Hospital, GAO found:

--In an unannounced check, all employees in a random sample of employees were either on the job or otherwise properly accounted for. (See p. 26.)

--The number of general care nursing hours provided to the patients did not meet State minimum requirements. In June 1976 the State suspended Kane Hospital's license and issued a provisional license due to insufficient general nursing care hours. (See p. 26.)

--Certain part-time employees worked without contracts and received county pension benefits on a basis different from other part-time hospital employees without the concurrence of the county retirement board. (See p. 27.)

FAMILY CONTRIBUTIONS

Kane Hospital properly credited the Medicaid program for contributions from relatives of patients. However, Kane Hospital may not have informed these relatives that contributions are supposed to be voluntary. (See p. 31.)

RECOMMENDATIONS

The Secretary of Health, Education, and Welfare (HEW) should require the Administrator of the Health Care Financing Administration to:

--Direct the State to amend its State plan and regulations and stop requiring the excessive accumulation of money for home maintenance in personal allowances at Kane Hospital.

--Direct the State to make sure that Kane Hospital patients get the required quarterly accounting of their personal needs accounts and that Kane Hospital get proper prior authorizations of expenditures from their accounts.

--Require the State, Kane Hospital, and other providers of services to Kane Hospital patients to follow proper Medicaid billing procedures.

--Assure that money earned through the investment of patients' funds is fairly distributed.

--Direct the State to offset Medicare Part B payments for facility-based physician services against Kane Hospital's Medicaid reimbursement for the cost of those services.

--Direct the State to recompute the Federal share of the Medicaid payments after considering and deducting the X-ray and laboratory costs allocated to and paid under Medicare Part B.

--Recover the Federal share of Medicaid overpayments to Kane Hospital.

--Assure that collections from Medicaid patients at Kane Hospital for Medicare Part B services cease and that restitution be made to living patients and the

issue of restitution to discharged patients and the estates of deceased patients be dealt with according to Pennsylvania law.

--Provide for the exchange of audit information between the Medicare intermediary and the State Auditor General.

## OFFICIAL COMMENTS

HEW's responses to GAO's recommendations were generally positive. HEW indicated that it had tried for 4 years to work out an exchange of audit information with the State without success.

The State indicated that it authorized payment of Medicare Part B coinsurance for Medicaid patients effective January 1977. The State did not agree that the accumulation of patients' funds was inconsistent with Federal regulations.

Kane Hospital reported that the problems in administering patients' funds were being corrected, that billings to patients' families had ceased, and that improvements had been made in meeting the State's nursing care hour requirements. However, Kane Hospital did not believe that the duplicate Medicare and Medicaid payments had been made.

# Contents


| | | Page |
|---|---|---|
| DIGEST | | i |
| CHAPTER | | |
| 1 | INTRODUCTION | 1 |
| | The Medicaid program and its administration | 2 |
| | Relationship between Medicaid and Medicare | 3 |
| | Medicaid billing procedures | 5 |
| | Scope of review | 6 |
| 2 | STATE POLICIES AND PRACTICES CONTRIBUTED TO INAPPROPRIATE USE OF PATIENTS' FUNDS | 7 |
| | Incorrect application of Federal regulations resulted in excessive accumulations of patients' funds | 7 |
| | Inappropriate use of patients' funds | 10 |
| | Patients' funds used to pay for covered services | 11 |
| | Patients' funds used to pay Medicare deductible and coinsurance | 12 |
| | Patients' funds used to pay amounts in excess of reasonable charges | 14 |
| | Undistributed interest | 15 |
| | Conclusions | 16 |
| | Recommendations | 18 |
| | HEW comments | 18 |
| 3 | CHARGING MEDICARE AND MEDICAID FOR THE SAME SERVICES RESULTED IN OVERPAYMENTS BY THE FEDERAL GOVERNMENT | 19 |
| | Payments of facility-based physician services under Medicare and Medicaid | 19 |
| | Effect on patients' funds | 21 |
| | Payment of X-ray and laboratory costs under Medicare and Medicaid | 22 |
| | Lack of audit coordination between Medicare and Medicaid | 24 |
| | Conclusions | 24 |
| | Recommendations | 25 |
| | HEW comments | 25 |

| CHAPTER | | Page |
|---|---|---|
| 4 | STAFFING PRACTICES AT KANE HOSPITAL | 26 |
| | Results of time and attendance check | 26 |
| | Number of general nursing care hours provided each day | 26 |
| | Retirement benefits for certain part-time employees | 27 |
| 5 | SOLICITATION OF FAMILY CONTRIBUTIONS | 30 |
| | Family contributions | 30 |
| | Conclusions | 32 |
| APPENDIX | | |
| I | Letter of February 18, 1977, from the Executive Director of John J. Kane Hospital | 33 |
| II | Letter of February 10, 1977, from the Secretary of the Pennsylvania Department of Public Welfare | 35 |
| III | Letter of March 4, 1977, from the Assistant Secretary, Comptroller of HEW | 37 |
| IV | Related GAO reports issued since 1972 | 43 |
| V | Principal HEW officials responsible for the administration of activities discussed in this report | 44 |


## ABBREVIATIONS

| | |
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| GAO | General Accounting Office |
| HEW | Department of Health, Education, and Welfare |
| HCFA | Health Care Financing Administration |
| SRS | Social and Rehabilitation Service |

## CHAPTER 1

## INTRODUCTION

At the request of the Chairman of the former Subcommittee on Long-Term Care, Senate Special Committee on Aging, we reviewed selected aspects of the management of John J. Kane Hospital as they related to the Medicaid program. Specifically, the Subcommittee requested that we:

--Review the management of patients' funds.

--Audit the 1974 Medicaid cost report.

--Ascertain the number of employees and whether these employees were actually working or properly accounted for at the time of our review.

--Determine whether Kane is requiring relatives of patients to make payments for the county's share of Medicaid reimbursements.

Kane Hospital is a public nursing home maintained and operated by Allegheny County, Pennsylvania. This 2,111 bed facility--the second largest of its kind in the United States--was opened in 1958 near Pittsburgh, Pennsylvania.

As a licensed facility, 1/ Kane furnishes skilled nursing 2/ and intermediate care 3/ and receives Federal financial support from the State's Medical Assistance Program (Medicaid). Under Medicaid, the Federal Government

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1/In June 1976, the State revoked Kane's license and issued a provisional license. (See p. 26.)

2/Skilled nursing is defined as nursing care or other rehabilitation services provided directly by or requiring the supervision of skilled nursing personnel on a daily basis.

3/Intermediate care is defined as health related care and services to individuals, on a regular basis, who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide. But, because of the individual's mental or physical condition, the patient requires care and services which can only be made available through institutional facilities.

and the State share in the health care costs of eligible persons--regardless of age--who cannot pay. Most of Kane's inpatient days of care during 1974 were to Medicaid patients.

In its 1974 cost report filed with Pennsylvania, Kane claimed $15,822,771 for inpatient services to Medicaid patients. The State Auditor General certified the cost report after reducing the total claim by $249,642.

Of the certified amount, $12,786,952 was for skilled nursing care and $2,786,177 was for intermediate care. Kane's costs averaged $23.60 and $15.24 a day for skilled nursing and intermediate care, respectively.

Kane also provides skilled nursing care under the Federal Medicare program. Although 550 beds in Kane (about one-fourth) are available for Medicare patients, only about 8,000 inpatient days were used by Medicare patients in 1974. The Medicare cost per day was about $30.80.

Kane's professional and nonprofessional staff consisted of more than 1,800 full-time and part-time employees. Salaries and related employee benefits account for about 72 percent of the total inpatient costs. The remaining 28 percent includes depreciation, food, supplies, plant operation, maintenance, etc.

## THE MEDICAID PROGRAM AND ITS ADMINISTRATION

Until March 8, 1977, the Department of Health, Education, and Welfare (HEW) administered the Medicaid program at the Federal level through its Social and Rehabilitation Service (SRS). SRS developed program policies, set standards, and was supposed to insure compliance with Federal legislation and regulations. On March 8, 1977, HEW was reorganized. The Medicaid program was placed along with Medicare in the new Health Care Financing Administration (HCFA) which assumed SRS's responsibilities for the Medicaid program.

Pennsylvania initiated and administers its Medicaid program, the nature and scope of which is contained in a State Plan for Medical Assistance. The plan is approved by HEW and is the basis for Federal financial participation. Title XIX of the Social Security Act establishes Federal cost sharing for medical benefit payments which is about 55 percent for Pennsylvania. Because Pennsylvania did not share in the costs of care to Medicaid patients in public

nursing homes, 1/ Allegheny County absorbed the remaining 45 percent.

In its Medicaid program, Pennsylvania provides skilled and intermediate nursing home care and physician services. Reimbursement to providers varies by type of service. For instance, public nursing home care is paid for on a per-diem rate adjusted annually to reflect actual cost. Payments to providers of prostheses and appliances, dental services, and outpatient hospital and clinic services are based on State fee schedules. Payment by the State for physician services can be made directly to the physician or to a nursing home through the per-diem rate if the physician is compensated by the nursing home. Participation in Medicaid is limited to providers who accept as payment in full reimbursement determined by the State Medicaid program.

If a State elects to have a Medicaid program, certain persons must receive specific medical services. These persons are called the categorically needy and include those who receive or are eligible to receive cash assistance payments from the Aid to Families with Dependent Children or Supplemental Security Income programs. 2/ A State may elect to offer medical services under the Medicaid program to an additional group of persons called the medically needy. In general, the medically needy are those persons whose income exceeds the upper income limit for cash assistance payments under the appropriate program, but whose financial resources are insufficient to meet all or part of their medical expenses. Pennsylvania offers medical services to both the categorically and medically needy persons under its Medicaid program.

## RELATIONSHIP BETWEEN MEDICAID AND MEDICARE

Title XIX of the Social Security Act requires the State and local authorities take reasonable measures to identify legally liable third parties to pay all or part of the cost

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1/According to a State official, the State will share in the cost of public nursing home care in the future.

2/Supplemental Security Income, under title XVI of the Social Security Act, is a Federal program which provides cash benefits to needy aged, blind, and disabled persons. Depending on circumstances, States must or may supplement the Federal cash benefit with State funds.

of medical care for Medicaid recipients. Medicare is an example of a third-party resource.

Many of Kane's patients are eligible for Medicare, which provides protection against the costs of health care for eligible persons, generally age 65 and over or disabled, under title XVIII of the Social Security Act.

Part A of Medicare (Hospital Insurance Benefits for the Aged and Disabled) offers a number of benefits, including inpatient hospital services and posthospital skilled nursing care services. Part A places a number of restrictions, including a maximum of 100 days of care per benefit period, on skilled nursing care for eligible persons. 1/ Only about 1 percent of Kane's inpatient days were covered by Part A, which does not offer intermediate nursing care.

Enrollment in Part B of Medicare (Supplementary Medical Insurance Benefits for the Aged and Disabled) is voluntary. It covers a number of medical and health benefits, including services of physicians who are employed by or compensated through hospitals and nursing homes, and certain X-ray and laboratory services provided to enrolled inpatients which are not covered by Part A. Part B is financed by general Federal revenues and monthly premiums collected from eligible individuals or from the State (on behalf of individuals also eligible for Medicaid through a buy-in agreement). Pennsylvania has a buy-in agreement through which the State pays the premiums for certain eligible persons.

Under its State plan, Pennsylvania agreed to provide the entire range of Part B benefits to persons with dual coverage under Medicare and Medicaid. The buy-in agreement covers monthly premiums for categorically needy individuals, but not for the medically needy. Pennsylvania also agreed to pay Medicare deductibles and coinsurance 2/ for the

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1/A benefit period starts when a Medicare beneficiary is hospitalized and ends when the beneficiary has not been an inpatient in a hospital or skilled nursing facility for 60 consecutive days.

2/Payment under Part B is limited to 80 percent of the reasonable charge for most covered services after an annual deductible of $60. The remaining 20 percent and the deductible are normally the responsibility of the patient. (See p. 12.)

categorically needy, as well as for medically needy who voluntarily pay premiums for Part B coverage.

## MEDICAID BILLING PROCEDURES

In Pennsylvania, a provider of services to a Medicaid patient must bill the State directly since the State will not reimburse the patient or a third party. Furthermore, a provider in the Medicaid program must accept the Medical Assistance payment as payment in full for the service provided. This State requirement is consistent with Federal regulation 45 CFR 250.30(a)(8).

Pennsylvania's Medicaid program requires providers to bill Medicare first when the patient has coverage under both Medicare and Medicaid. After payment is received from Medicare, the provider must submit a Medicaid claim form to the State with a copy of the Medicare explanation of benefits which explains how much was billed, how much was allowed as Medicare's reasonable charge, and how much was paid-- reasonable charge less deductible and coinsurance amounts. The State then should pay the difference between the amount paid by Medicare and the State's maximum allowable fee schedule. The State's fee may be lower than or equal to Medicare's reasonable charge, but may not be higher. A State official told us that submission to the State of the Medicaid claim form by the provider constitutes an agreement by that provider to accept payment based on Medicaid's reasonable charge determination as payment in full.

Limiting payment to State fee schedules could result in a billing which would not be payable by the patient or by either Medicare or Medicaid. For example, Medicare Part B recognizes a $10 fee as a reasonable charge for a particular service, but Medicaid limits the fee to $9. Assuming the deductible had been satisfied, Part B would pay 80 percent of $10 or $8. Because the Medicaid fee schedule limits payment to $9, Medicaid payment to the provider would be limited to $1. Thus, the providers's receipt of $8 from Part B and $1 from Medicaid would leave an unpaid balance of $1, which would not be the responsibility of either program or of the patient. By submitting the claim to Medicaid, the provider had agreed to accept the Medicaid fee schedule determination of $9 as payment in full.

## SCOPE OF REVIEW

We reviewed selected aspects of Kane's 1974 Medicaid cost report, including examining the basis of reimbursement, tracing expenses claimed to hospital records, analyzing selected cost elements to determine the accuracy and reliability of costs reported, and comparing this cost report to the Medicare cost report. We also examined Kane's sources of income and its policy on soliciting contributions from patients' relatives.

We reviewed Kane's procedures and practices for managing and accounting for patients' personal funds, including receipts and disbursements. We sampled January 1976 transactions to determine the authority and purpose for disbursements.

We conducted an unannounced time and attendance check for a number of randomly selected Kane employees. We also reviewed payroll policies and procedures and checked on staffing levels for general nursing care.

We reviewed selected Federal and State regulations as they related to our objectives and discussed all aspects of our review with Kane officials.

Copies of a draft of this report were sent to Kane, the State, and HEW for their comments, which are included as appendixes I, II, and III, respectively.

## CHAPTER 2

## STATE POLICIES AND PRACTICES CONTRIBUTED TO INAPPROPRIATE USE OF PATIENTS' FUNDS

Generally, Kane's patients were long term and accumulated in their personal accounts, maintained by Kane, a $25-a-month personal needs allowance. Contrary to Federal regulations, these patients accumulated as much as $150 a month extra for the first 6 months of their stay for use in maintaining a home. This money, which was retained in accordance with State regulations, was not used to maintain homes. Instead, Kane used it to pay for

--patients' services which were covered by and payable by either the Medicare Part B or Medicaid programs or both,

--patients' Medicare Part B deductible and coinsurance which were payable by the Medicaid program, and

--amounts in excess of Medicare Part B prevailing reasonable charge determinations which were not payable by patients or either program.

Kane had managed the financial affairs of many patients without obtaining proper written authorization. Moreover, Kane was not giving patients the required quarterly accounting of financial transactions made on their behalf. Finally, Kane had not distributed to individual patients' accounts more than $217,000 of interest earned since 1970 through investment of patients' funds because the State and HEW had failed to give adequate guidance in this regard.

### INCORRECT APPLICATION OF FEDERAL REGULATIONS RESULTED IN EXCESSIVE ACCUMULATIONS OF PATIENTS' FUNDS

Federal and State regulations include provisions concerning the rights and responsibilities of patients. They provide, in part, that before or at the time of admission and during their stay in an institution, patients be fully informed of all charges, including charges for services not covered under Medicare and Medicaid. Patients have the right to manage their own affairs. Federal regulations require that Medicaid patients in a nursing home be allowed to keep some of their income for clothing and such incidentals as reading matter, small gifts, toiletries, etc., not provided by the facility. For aged, blind, and disabled individuals

receiving Supplemental Security Income benefits, the amount for personal needs must be a minimum of $25 a month. For other Medicaid patients it is an unspecified "reasonable" amount to be established by the State. Any income above the personal needs level must be applied to the cost of care in the facility.

If a facility accepts responsibility for a patient's financial affairs, transfers of funds must be in writing. Further, a facility must give each patient at least a quarterly accounting of all financial transactions. Kane assumed responsibility for managing many patients' funds without obtaining all necessary written authorizations and gave an accounting of transactions only when patients or their representatives requested an accounting. Requests for accounting were rare. In February 1977, Kane's Executive Director told us that the quarterly accountings were still not being given, but efforts were being made to correct the situation.

In our sample of 30 patients' funds disbursements, we found that Kane obtained some authorization from 12 patients. Kane had obtained the patients' authorization to receive all income and deposit all checks without personal endorsement. The signed statements also authorized Kane to deduct payments for nursing home care, provide a personal allowance, and accumulate any unspent personal funds. Kane did not generally consult patients before disbursing their funds or fully inform them of all charges to their accounts. Simply stated, Kane generally had the authorizations to receive money for patients but not to spend it.

If a physician certifies that a patient is likely to return home within 6 months, Federal regulations (45 CFR 248.3 (b)) allow that individual to apply income and resources toward maintaining a home. The regulations require that any income over the home maintenance allowance, if any, and the personal needs allowance be applied to the cost of the patients' medical care. The State has followed a policy of requiring Kane patients, during the first 6 months of their stay, to keep some income for the purpose of maintaining a home even though Kane's patients are generally long term. We found no instances where an individual who was accumulating the home maintenance allowance had been certified by a physician as likely to be discharged within 6 months of admission, and we found no instances where funds accumulated in the first 6 months were used to maintain patients' homes. Kane patients accumulated up to $150 a month for home maintenance and $25 for personal needs.

In a September 1972 letter to the State, Kane challenged the reasonableness of the State regulation requiring all patients to accumulate funds for home maintenance. Kane's Executive Director made the following comment about the home maintenance allowance.

> "This, of course, is a worthwhile endeavor. However, while the primary objective of all County owned and operated institutions is the improvement of a patient's health and his return to the community, it is not an attainable goal in the majority of cases treated. The history of County Institutions is such that only the long term, chronic, and terminal patients are admitted. The hope for discharge is limited as evidenced by the fact that the average length of stay in County Institutions is approximately 4.6 years, while the rate of discharge is less than 5 percent of all cases admitted."

Almost a year later, the State advised Kane that the regulation was a Federal requirement, which the State could not change. Federal regulations do, in fact, permit the home maintenance allowance, but only when the patient is likely to return home within 6 months. As stated previously, physicians were not certifying that Kane patients were likely to return home within 6 months.

For the month of January 1976, more than 2,100 Kane patients had income from various sources totaling $369,327. Of this amount, $280,530 was applied toward the cost of nursing home care and the remainder was deposited in patients' accounts. More than 200 patients, whose stay had not yet exceeded 6 months, were allowed to retain income up to $175 for the month, including $25 for personal needs.

We randomly sampled 30 of the 260 miscellaneous disbursement transactions from patients' accounts in January 1976 to determine how funds were used. Our sample showed that no money accumulated in the first 6 months was used to maintain patients' homes. In general, Kane used home maintenance allowances to pay for what it considered to be other obligations of the patients. Some payments were for medical care which was not the patients' obligation. (See pp. 10 to 15.)

Kane estimated that the cost to the Medicaid program could be reduced by about $732,000 annually if the home maintenance allowance was discontinued. This estimate was

based on 1,000 annual admissions with an average maintenance allowance of $122 a month for a period of 6 months each.

If the home maintenance allowances for Kane patients were discontinued, except in those cases in which a physician certifies that a patient is likely to return home within 6 months, all patient income over the $25 personal needs allowance would be applied to nursing home care. This would have reduced the amount of costs for Federal and county financial participation. Although we did not develop an independent estimate of the total reduction in Medicaid costs, we believe Kane's estimate is reasonable in terms of gross dollar reductions. For example, during [illegible] there were 968 admissions. In January 1976, more [illegible] 200 patients whose stay had not yet exceeded 6 months retained an average income of about $150. By properly applying the Federal regulations on home maintenance allowances, the Federal share of Medicaid costs could be reduced by as much as $400,000 annually ($732,000 X 55 percent). The actual net dollar impact on the Medicaid program in the aggregate, however, is less than $732,000 because while the entire $732,000 was incorrectly diverted from paying for one Medicaid service (nursing home care), a portion was used to pay for other medical services which should have been paid for by the Medicaid program but were not.

In its comments on a draft of this report, the State denied that the accumulations were excessive or contrary to Federal regulations. HEW, in contrast, agreed that the State was not following applicable Federal regulations and indicated that the State would be required to bring its State Medicaid plan into conformance with the regulations.

## INAPPROPRIATE USE OF PATIENTS' FUNDS

Kane used Medicaid patients' funds to pay for services which were covered under the Medicare and Medicaid programs. Also, it used patients' funds to pay charges for services which were in excess of reasonable charge determinations or maximum fee limitations which neither the Medicare nor the Medicaid program would pay. In addition, the State had not complied with provisions of its own State plan, approved by HEW, which provided that the Medicaid program would pay the Medicare Part B deductible and coinsurance. Instead, State regulations, in violation of the State's agreement with the

Federal Government, prohibited the payment of Part B coinsurance for health care costs. 1/

Our review of patients' funds for January 1976 showed that 260 disbursements, totaling $58,017, were made during the month. Our sample of 30 transactions, totaling $5,715 from 30 patients' funds, showed disbursements from 8 patients' accounts for covered services, the Medicare Part B deductible and coinsurance, or charges in excess of reasonable charge determinations.

## Patients' funds used to pay for covered services

Kane spent patients' funds for services covered under the Medicare and Medicaid programs. This occurred, in part, because of (1) a lack of understanding of the services covered by Medicare and Medicaid and (2) failure to follow proper billing procedures for such services. Our sample showed that disbursements were made from four patients' funds for services covered under both programs.

The following are two examples of such payments.

--It was Kane's policy to pay ambulance service bills with patients' funds without consulting the patients. The State Medicaid program pays for ambulance service up to $75 per trip for both categorically and medically needy individuals. In addition, ambulance services are covered under Part B of the Medicare program for individuals having Medicare Part B coverage. Although only one disbursement of $35 for ambulance service for one patient was identified in our sample, Kane paid for ambulance services for 15 other patients between November 5 and December 26, 1975, with a single check written against the patients' fund account. Therefore, 16 patients paid $35 each, or $560, for ambulance service. A Kane official told us he was not aware that ambulance services were covered by the Medicare Part B and Medicaid programs. In February 1977, however, other Kane officials told us that Kane had begun to routinely bill Medicare for ambulance services after we brought the matter to their attention.

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1/State regulations were revised effective Jan. 1, 1977, to authorize the payment of both deductibles and coinsurance. (See p. 13.)

--The State Medicaid program covers prosthetic devices for categorically needy individuals. In addition, the Medicare program covers prosthetic devices under Part B. However, $54.90 was taken from a patient's fund to pay a brace company's bill. The brace company had refused to bill the Medicare program. We found no evidence that Kane made any attempt to have the provider obtain payment from either the Medicare or Medicaid programs.

Although our sample of transactions was small, we found it was Kane's general policy to pay billed charges from providers for services covered by the programs. According to Kane officials, bills were accepted from providers because they had been unable to get providers to bill the programs directly. These officials believed they could use any patient's funds, except money accumulated from unspent portions of the $25-per-month personal needs allowance, to pay for covered medical care. In February 1977, however, other Kane officials agreed with us that the patients' funds should not be used to pay for covered medical care.

Patients' funds used to pay Medicare deductible and coinsurance

Kane patients, eligible for Medicare Part B coverage, paid a portion of the cost of medical services although that portion is covered under Medicaid. Payment was made through the patients' funds.

Most of Kane's patients are covered by Medicaid. Also, many are 65 years or older and, therefore, qualify for coverage under Part B of the Medicare program. 1/ Enrollment under Part B is voluntary, except that categorically needy recipients are automatically enrolled by the State which pays the Part B premiums. When a patient is eligible under Medicare Part B and Medicaid, the cost of services is first billed to the Medicare program. Payment under Part B is limited to 80 percent of the allowable (reasonable) cost or reasonable charges, after an annual deductible of $60. The remaining 20 percent and the deductible are normally the responsibility of the patient.

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1/Some patients at Kane were covered by the posthospital skilled nursing home benefits under Part A of Medicare. However, during 1974 this coverage represented about 8,000 days or about 1 percent of the total patient days at Kane.

The State, through its HEW-approved State plan, obligated itself to pay the deductible and coinsurance for categorically needy recipients as well as other individuals who voluntarily paid premiums for Part B. But, State regulations prohibited the payment of the Part B coinsurance, in violation of the State plan, and limited payment of the Part B deductible to an amount established on the State's fee schedule.

Payment of the Medicare Part B deductible and coinsurance by Kane Medicaid patients also occurred because Kane accepted and paid provider bills which the provider should have sent to the State agency responsible for paying Medicaid bills. Our sample showed that disbursements were made from four patients' funds for Part B deductibles and coinsurance.

The following is an example of this misapplication of patients' funds.

--A brace company made repairs to a brace and billed Kane $63. Kane accepted and paid the bill with money from the patient's account and then sent the bill to Medicare. Medicare deducted $60 and applied it to the patient's deductible. Medicare paid the patient 80 percent of $3.00 or $2.40. The $2.40 was deposited in the patient's account. Nothing was paid by Medicaid since the claim was not sent to the State agency. The 20 percent coinsurance would not have been paid by the State since State regulations in effect at that time incorrectly prohibited payment of Medicare coinsurance although they provided for paying the deductible.

It was Kane's standard practice to pay the Part B deductible and coinsurance with patients' funds wherever possible. One significant example of Kane's practice was the use of patients' funds to pay the deductible and coinsurance on Medicare Part B payments of hospital-based physician salaries. From 1972 to 1974, such erroneous payments from patients' funds may have amounted to as much as $441,000. (See ch. 3.)

State regulations were revised January 1, 1977, to provide that the State will pay for Part B coinsurance. However, like the deductible, payments will be limited to amounts specified on the State fee schedules. Although the revision of State regulations brought the State into compliance with its State plan, both the providers and the State will have to follow proper billing procedures to ensure payments are made correctly by Medicaid.

## Patients' funds used to pay amounts in excess of reasonable charges

Patients' funds were used to pay amounts in excess of the reasonable charge determined by Medicare Part B. 1/ This situation occurred when providers submitted claims to Kane, whether before or after payment by Part B. Kane assumed the State agency's responsibility and made payment with patients' funds.

State procedures require providers to submit claims to Medicaid. If payment is first made by Part B, the provider must submit the claim to Medicaid with an explanation of Part B benefits (routinely supplied by Medicare) and a State claim transmittal form. Medicare Part B payment data is not transferred directly to the State agency. However, Kane accepted and paid the claims from the patients' funds and did not submit them to the State agency. Furthermore, payment could not be made to Kane or the patient because the State would pay only the provider of services.

Under Medicare, Part B payments may be made to the beneficiary or to the physician or others providing the services. Payments made directly to the provider are on assigned claims; that is, the provider bills Medicare Part B and agrees to accept the reasonable charge determination as payment in full. On assigned claims, the provider should not collect from the patient any amount in excess of the portion of the reasonable charge not paid by Medicare. If the provider does not accept assignment, it is an unassigned claim. Under an unassigned claim, the provider bills the patient and the patient in turn sends the bill to Medicare. The provider has not agreed to accept the reasonable charge determination and may collect an amount in excess of the Medicare reasonable charge from the patient. Under Medicaid, by contrast, all claims are, in effect, assigned claims because payment based on Medicaid's maximum allowable fee is defined in State and Federal regulations to be payment in full. In the case of Pennsylvania Medicaid eligibles, the State is obligated under its State plan to pay the patients' share not reimbursed by Medicare up to the amount of the State's maximum fee.

Medicaid patients at Kane paid amounts in excess of reasonable charge determinations on both assigned and unassigned Medicare claims. The following examples of payments were found in our sample of patient fund disbursements.

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1/The Medicaid maximum allowable fee may not exceed the Medicare reasonable charge. (See p. 5.)

--A physician performed a surgical procedure on a Kane Medicaid patient, covered under Part B, at another area hospital. The physician submitted an assigned claim with a total charge of $80. A charge of $40 was approved by Medicare, and since the deductible had already been satisfied, Part B paid the physician $32. Instead of submitting a claim to the State for $8, the physician sent a bill for $48 to Kane, which paid it with the patient's funds. The patient, in this instance, paid the $8 coinsurance plus $40 in excess of the Medicare reasonable charge.

--A Kane Medicaid patient, covered under Part B, received radiation therapy as an inpatient and outpatient at another area hospital. The physician sent a bill for $825 to the patient at Kane. The patient's funds were used to pay the bill in full, and Kane sent the unassigned claim to Medicare. A total of $546 was approved--$320 for outpatient services and $226 for inpatient services. Part B paid 80 percent of the approved outpatient fee and 100 percent of the aproved inpatient fee for a total of $482. Kane deposited the $482 in the patient's account. The patient, in this instance, paid $64 coinsurance plus $279 in excess of the Medicare reasonable charge.

Although our sample disclosed only two instances where patients' funds were used to pay amounts in excess of Medicare reasonable charge determinations, it was Kane's general policy to accept claims from providers either before or after partial payment by Medicare. This policy circumvented State regulations requiring the provider of services to submit claims directly to the State agency. In addition, Kane's use of Medicaid patient's funds circumvented the State's claim processing procedures for providers. Kane did not submit the claim to the State after the providers were paid; and, even if it had, State regulations restrict payment to providers only.

## UNDISTRIBUTED INTEREST

When a patient entered Kane, a record was opened for recording all receipts and disbursements on the patient's behalf. Patients' funds were combined and deposited in a general checking account.

In April 1970, Kane began investing otherwise idle patients' funds in interest-bearing savings certificates. The interest income from these certificates was put into an

interest-earning savings account. As of January 1976, patients' funds amounted to $1,317,983, of which $217,222 represented earned interest. None of the earned interest was ever distributed to individual patient's accounts.

In March 1976, we issued a report 1/ which stated that HEW had not provided the States with adequate guidance concerning the management of patients' funds by nursing homes. SRS had concluded at least as early as August 1975 that a nursing home must not charge a fee for managing patients' funds and that interest earned on patients' funds should accrue to the individual patients. But over a year later, in November 1976, Pennsylvania issued proposed regulations which authorize fees for managing patients' funds and permit nursing homes to use earned interest for special activities benefiting all patients as a group or apply the earned interest to each patient's account at the nursing home's discretion. In February 1977, an HEW official told us that HEW was preparing proposed regulations concerning the management and monitoring of patients' funds.

Kane's Executive Director told us that he agreed with us that improvements have to be made in handling patients' funds at Kane. Later, in Kane's formal comments on our draft of this report, he indicated that an independent fiscal agent would be used to handle patients' funds and that Kane had established practices to eliminate the improper utilization of patients' funds to pay for services covered by the Medicare and/or Medicaid programs.

## CONCLUSIONS

The State followed a policy which is contrary to Federal regulations whereby, for the first 6 months of their stay, Kane patients routinely accumulated personal income for the purpose of maintaining a home. Most of Kane's patients were long term and physicians had not certified that they were likely to be discharged within 6 months. The general application of the State's policy provided funds to patients which were not used for home maintenance.

Patients' funds accumulated for home maintenance were used for (1) patients' services covered and payable by

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1/"Improvements Needed in Managing and Monitoring Patients' Funds Maintained by Skilled Nursing Facilities and Intermediate Care Facilities," MWD-76-102, Mar. 18, 1976.

either Medicare Part B or Medicaid, (2) patients' Medicare Part B deductible and coinsurance which were payable by Medicaid, and (3) the payment of amounts in excess of Medicare Part B reasonable charge determinations which were not properly payable by patients or either program.

Kane's inappropriate use of patients' funds occurred because:

--Home maintenance allowances were improperly accumulated due to State regulations which were in conflict with Federal regulations.

--Kane used the home maintenance allowances to pay for what it incorrectly considered to be obligations of the patients.

--Kane (1) lacked understanding of the services covered by Medicare and Medicaid and (2) failed to follow proper billing procedures for such services.

--State regulations covering Medicare deductibles and coinsurance for Medicaid patients did not comply with the State plan.

--Kane accepted payment responsibilities belonging to the State agency.

If the home maintenance allowances for Kane patients were discontinued, except in those cases in which a physician certifies that a patient is likely to return home within 6 months, most patient income over the $25 personal needs allowance would be applied to nursing home care. This would have reduced the amount of costs for Federal and county financial participation in nursing home care.

By properly applying the Federal regulations on home maintenance allowances, the Federal share of Medicaid nursing home costs could be reduced by as much as $400,000 annually ($732,000 X 55 percent). The actual dollar impact on the Medicaid program in the aggregate, however, is less than $732,000 because a portion was used to pay for other medical services which should have been paid for by the Medicaid program but were not.

In many instances, Kane was spending patients' funds without proper authorization and was not giving patients or their representatives an accounting of transactions made on the patients' behalf. In addition, a substantial amount of earned interest has never been distributed to patients' accounts due, we believe, to HEW's failure to publish regulations concerning the management and monitoring of patients' funds.

## RECOMMENDATIONS

We recommend that the Secretary of HEW require the Administrator of HCFA to:

--Direct the State to amend its State plan and regulations and stop requiring the accumulation of home maintenance allowances at Kane except where the home maintenance allowance is justified according to Federal regulations.

--Direct the State to make sure that Kane patients get the required quarterly accounting of their personal needs accounts and that Kane get proper prior authorizations for expenditures from those personal needs accounts.

--Require the State, Kane, and other providers of services to Kane patients to follow proper Medicaid billing procedures.

--Assure that money earned through the investment of patients' funds is fairly distributed.

## HEW COMMENTS

HEW generally agreed with our conclusions and recommendations. The one exception concerned home maintenance allowances. HEW agreed that the State did not meet Federal requirements, but did not believe that it could disallow Federal financial participation as we had proposed since Pennsylvania's State Medicaid plan did not require the certification of a physician that an individual is likely to return home within 6 months. HEW promised to instruct the State to correct its State plan to comply with Federal regulations. Since the requirements of 45 CFR 248.3(b) are applicable to the State of Pennsylvania, we do not believe that the problems involving the accumulation of the home maintenance allowance are caused solely by the failure of the State plan to require a physician to certify each patient as likely to return home within 6 months. The home maintenance allowances were accumulated because the State required them to be accumulated. We are willing to accept HEW's promised action regarding the improper accumulation of home maintenance allowances, but we do not agree that the home maintenance allowances are improperly accumulated due to that defect in the State plan cited by HEW. The plan authorizes the allowance only for those persons expected to return home within 6 months, although it fails to mention physician certification as the method of confirming the expectation that the patient will return home within 6 months. The State plan does not authorize inappropriate accumulations.

## CHAPTER 3

## CHARGING MEDICARE AND MEDICAID FOR THE SAME SERVICES RESULTED IN OVERPAYMENTS BY THE FEDERAL GOVERNMENT

From 1972 through 1974 Kane received overpayments of more than $510,000 for the Federal share of its Medicaid costs because Kane incorrectly claimed more than $942,000 of facility-based physician service costs which had been reimbursed by Medicare Part B. In addition, about $145,000 in Federal overpayments resulted because $262,000 in X-ray and laboratory costs were reimbursed by Medicare Part B but were not considered in calculating Medicaid costs. Kane may also have collected as much as $441,000 from patients' personal funds for facility-based physician service costs and $160,000 in X-ray and laboratory costs which were also reimbursed through its Medicaid cost report. These collections from patients' funds were for the deductible and coinsurance amounts not reimbursed by Medicare Part B.

### PAYMENTS OF FACILITY-BASED PHYSICIAN SERVICES UNDER MEDICARE AND MEDICAID

Kane employed about 30 full-time and part-time doctors and had agreements with a number of other area doctors who provided services on a fee-for-service basis. These doctors are "facility based" and their salaries and fees were allowable costs under both Medicare and Medicaid. However, as explained below, Medicare Part B reimbursements for the cost of services to individual patients should have been offset against costs claimed for reimbursement under Medicaid.

Medicare pays for facility-based physician service costs in two ways. Part A pays for the cost of administrative and supervisory services which benefit patients as a group, and Part B pays for the costs of professional medical services provided to individual patients. Medicaid, by contrast, does not make this distinction between administrative and professional medical services in calculating reimbursement for facility-based physician services. Medicare Part B reimburses Kane for physicians' professional services provided to patients for those days of skilled nursing care covered under Part A. In addition, Part B reimburses Kane for physicians' professional services provided to patients for those days of skilled or intermediate nursing care covered under Medicaid, if the patient is also eligible for Medicare Part B.

For 1974 Medicare's paying agent (or "carrier") approved a reimbursement rate of $.71 per day for each patient eligible for Part B physician services. Kane's approved billing to Medicare Part B was $409,382 for about 581,000 days of care, of which about 573,000 days were for patients covered by Medicaid and Part B. Kane was paid only $295,618 because reimbursement under Part B was limited to 80 percent of the amount approved for payment after reductions for each patient's annual deductible of $60.

Under the Medicaid program, payments to Kane were based on audited costs certified by the State Auditor General. Kane's 1974 certified costs for skilled and intermediate nursing care were $23.60 and $15.24 per day, respectively. Kane's 1974 Medicaid cost report should have offset the cost of facility-based physician services by the applicable Medicare reimbursement. However, Kane's 1974 Medicaid cost report included the total cost incurred for facility-based physician services, although $295,618 had already been reimbursed by Medicare Part B. As a result, Kane was paid twice for facility-based physician services for each day these services were provided to a Medicaid patient who was covered by Part B. The Federal share of the 1974 overpayment was $160,331 ($295,618 X 55 percent).

We examined the same sets of records for 1972 and 1973 and identified overpayments in both years occurring for the same reasons as in 1974. Overpayments of more than $510,000 of Federal funds for 1972 through 1974 are shown in the following table.

| Year | Facility-based physician service costs for Medicare Part B payments (note a) | | | Federal share of estimated Medicaid overpayments |
|---|---|---|---|---|
| | Billed | Allowed | Paid | |
| 1972 | $ 551,419 | $ 538,714 | $327,036 | $177,371 |
| 1973 | 436,291 | 435,896 | 319,473 | 173,269 |
| 1974 | 409,583 | 409,382 | 295,618 | 160,331 |
| Total | $1,397,293 | $1,383,992 | $942,127 | $510,971 |

a/These amounts do not include smaller sums billed to and paid by another Medicare carrier. Therefore, estimated overpayments are slightly understated.

When we first discussed these overpayments with Kane officials in mid-1976, they acknowledged that there was a duplicate payment, but they claimed that it was standard practice

and had the State's approval. 1/ In February 1977, we discussed a draft of this report with other Kane officials and, as indicated in Kane's comments, they were not convinced that the overpayments had occurred.

## EFFECT ON PATIENTS' FUNDS

When Medicare reimbursed Kane for facility-based physician services under Part B, the actual payment was limited to the amount approved for payment, less the $60 deductible and 20 percent coinsurance. For example, for one Medicaid patient covered by Part B, Kane billed the Medicare carrier for 273 days of care at the approved billing rate of $.71 per day. The carrier's payment to Kane was computed as follows:

| | |
|---|---|
| Allowed at the per diem rate | $193.83 |
| Less annual deductible | 60.00 |
| Balance | 133.83 |
| Total Medicare payment to Kane (80 percent of balance) | $107.06 |

The amount not paid by Medicare ($86.77 representing the deductible and 20 percent coinsurance) was deducted from the patient's personal needs account. The standard practice at Kane at the time of our review was to recover the deductible and coinsurance from patients whenever patient money was available. This practice had the effect of Kane's recovering the amounts not reimbursed by Medicare Part B from both the patient and Medicaid since it was Kane's practice to include the total cost incurred for facility-based physican services in its Medicaid cost reports.

For 1972 through 1974, Kane may have collected from the patients' funds as much as $441,000--allowable facility-based physican cost less Medicare Part B payments. Any part of the $441,000 not collected by Kane represents approved Medicare Part B billings not paid to Kane because of deductibles and coinsurance applying to patients who did not have enough money in their personal needs accounts.

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1/A State official told us that the duplicate payments did not have State approval. He said that one reason that the State has difficulty in detecting such overpayments is the failure of Medicare to share the results of its audits of Medicare cost reports with the State. (See p. 24.)

## PAYMENT OF X-RAY AND LABORATORY COSTS UNDER MEDICARE AND MEDICAID

Unlike many nursing homes, Kane maintained X-ray and laboratory departments to provide services to its inpatients. The costs of these departments were included in the Medicaid per-diem rates. Medicare pays for these costs in two ways. In addition to X-ray and laboratory services provided to Medicare inpatients under Part A (and paid by Part A), participating institutions may also receive payment under Part B for such services provided to inpatient beneficiaries who are not eligible inpatients under Part A. These payments, which are on a cost basis, are administered by the same paying agent (intermediary) that administers the payments, audits, and cost settlements under Part A.

Kane had claimed reimbursement for the costs of the inpatient X-ray and laboratory services covered by Part B, but the allocated costs and the related payments were not considered in calculating Medicaid's reimbursable costs. As a result, the costs allocated to Medicare Part A and B and to Medicaid substantially exceeded the total costs of providing X-ray and laboratory services at Kane, including those provided to any inpatients not eligible for either Medicare or Medicaid.

For example, our comparisons of the audited 1974 cost reports for Medicare and Medicaid showed that the costs allocated to these programs were about 160 percent of the total costs of these departments as follows.

| | | |
|---|---|---|
| Total costs of X-ray and laboratory departments (as per Medicare) | | $288,400 |
| Costs allocated to Medicare: | | |
| Part A | $ 5,500 | |
| Part B (note a) | 171,600 | 177,100 |
| Costs allocated to Medicaid | | 280,900 |
| Costs allocated to Medicare and Medicaid | | 458,000 |
| Costs allocated to Medicare and Medicaid in excess of total costs | | $169,600 |

a/Based on 1973 costs claimed and audited in 1974 because Kane has generally been one year behind in its Part B ancillary service billings.

while Medicaid and Medicare Part A theoretically paid for the costs of the services provided for the inpatient days covered by the respective programs, the cost allocated to Part B had the effect of duplicating or overlapping the costs allocated to Medicaid.

For the period 1972 through 1974, the X-ray and laboratory costs allocated to Medicare Part B totaled about $442,000. Because the Part B inpatient X-ray and laboratory services were subject to the same deductible and coinsurance provisions as the facility-based physician services, $262,000 of the costs was paid by the intermediary and the remaining $160,000 was charged to the patients and may have been collected by Kane from the patients' funds.

The Federal share of the $262,000 paid by the intermediary but not considered and deducted in determining the Medicaid payment rates was about $145,000.

In addition to the $422,000 in Part B inpatient X-ray and laboratory costs (discussed above) applicable to 1973, 1972, and 1971, the Medicare intermediary records show that for the 1972 reporting period, Kane filed and settled claims involving Part B inpatient X-ray and laboratory costs, totaling about $263,000 for 1969 and 1970.

In commenting on the general subject of duplicate billing under Medicaid and Medicare (see app. I), Kane advised us that

> "We do not believe that duplicate billing by us has taken place to the Medicare and Medicaid Programs. In the absence of proper documentation for previous years' cost reports it is impossible for us to completely verify the multiple billing practices which would show that total revenues and total expenditures were completely in order and within the law and regulations. We are confident, however, that no erroneous payments were made from patient funds but that any payment problems were to the detriment of the County taxpayers' dollar and not to Federal, State or patient monies."

As discussed above, our analysis and comparison of the audited Medicare and Medicaid cost reports on which final payments to Kane were based, showed that duplicate charges and/or overlapping allocation of costs did occur with respect to Medicaid and Part B of Medicare, and that it was to the detriment of the Federal Government.

## LACK OF AUDIT COORDINATION BETWEEN MEDICARE AND MEDICAID

Within HEW, the Social Security Administration had primary responsibility for administering the Medicare program. On March 8, 1977, this responsibility shifted to HCFA. HEW has contracted with various private organizations--such as Blue Cross--to act as intermediaries in the administration of Medicare Part A payments to institutional providers as well as Medicare Part B payments for outpatient services and inpatient ancillary services not covered by Part A. In addition, other private organizations--such as Blue Shield--act as carriers and administer Medicare Part B, making payments to providers, such as physicians, laboratories, etc.

Under Medicare, skilled nursing care, as provided by Kane, is reimbursed on the basis of reasonable costs which are shown on the Medicare cost report. Kane's cost report had been audited by a Medicare intermediary. For cost elements such as facility-based physician salaries, the intermediary reviews nursing home costs and advises Medicare Part B carriers of the share of physician professional medical service costs attributable to Part B.

In Pennsylvania, payment to county nursing homes for Medicaid patient care is based on costs filed by the nursing home with the State Auditor General. Payment of the Federal share of Medicaid costs is based on the State Auditor General's audit of the Medicaid cost report. However, Medicare cost reports and reimbursement data is not routinely made available to the State Auditor General. As our findings above illustrate, proper reimbursement under either program cannot be assured without comparison of audit reports, findings, and payment data.

## CONCLUSIONS

Kane was overpaid about $655,000 for the Federal share of Medicaid costs for 1972 through 1974 because proper adjustments were not made for Medicare Part B payments for facility-based physician service costs and for X-ray and laboratory costs. In our opinion, these overpayments were not detected because Medicare and Medicaid reimbursement data was not exchanged between the programs.

In addition, Kane's recovery of deductible and coinsurance amounts, not paid by Part B, from patients' funds also resulted in duplicate reimbursement of these amounts. Kane could have collected as much as $601,000 from the

patients' funds from 1972 through 1974. Medicare Part B deductibles and coinsurance for Medicaid eligibles are properly chargeable to the State Medicaid program. (See p. 12.)

## RECOMMENDATIONS

We recommend that the Secretary of HEW require the Administrator of HCFA to:

--Direct the State to offset Medicare Part B payments for facility-based physician services against Kane's Medicaid reimbursement for the cost of those services.

--Direct the State to recompute the Federal share of the Medicaid payments after considering and deducting the X-ray and laboratory costs allocated to and paid under Medicare Part B.

--Recover the Federal share of Medicaid overpayments to Kane.

--Assure that collections from Medicaid patients at Kane for Medicare Part B services cease and that restitution be made to living patients and the issue of restitution to discharged patients and the estates of deceased patients be dealt with according to Pennsylvania law.

--Provide for the exchange of audit information between the Medicare intermediary and the State Auditor General.

## HEW COMMENTS

The issue of the duplicate or overlapping allocation of X-ray and laboratory costs to Medicare Part B and Medicaid had not been included in the version of the report reviewed by HEW, because the audited cost reports obtained from Kane did not include those portions pertaining to the Part B settlement. The information was subsequently obtained from the intermediary. Therefore, HEW did not have an opportunity to respond to the related recommendation. However, with respect to the remaining recommendations, HEW generally agreed to recompute the amounts Kane should have received under Medicaid from 1972 forward and to disallow the Federal share of the overpayment that occurred.

With respect to the exchange of audit information between the Medicare intermediary and the State Auditor General, HEW pointed out that for the past 4 years HEW had made extensive efforts to work out a common audit agreement with the State but that such efforts had been unsuccessful.

## CHAPTER 4

## STAFFING PRACTICES AT KANE HOSPITAL

We reviewed Kane's staffing practices and related recordkeeping and found:

--In an unannounced check all employees in a random sample of employees were on the job or otherwise accounted for.

--The number of general care nursing hours provided to the patients did not meet State minimum requirements.

--Certain part-time employees worked without contracts and received county pension benefits on a basis different from other part-time hospital employees without concurrence of the county retirement board.

### RESULTS OF TIME AND ATTENDANCE CHECK

We made an unannounced time and attendance check of Kane's employees to determine whether the employees were properly accounted for. We selected a random sample of the 1,834 full-time and part-time employees on Kane's payroll as of March 27, 1976. Our sample included professional and nonprofessional employees; persons working on each of three shifts; and administrative, clinical service, food service, and maintenance employees.

All employees in the sample were either on the job or properly accounted for.

### NUMBER OF GENERAL NURSING CARE HOURS PROVIDED EACH DAY

State and HEW reviews have identified a lack of sufficient nursing staff as a major problem at Kane. Our review showed that during a 2-week period, the number of general nursing care hours provided by Kane to skilled and intermediate care patients did not meet State minimum requirements.

Effective January 1, 1976, Pennsylvania's Department of Public Welfare required nursing homes to provide a minimum of 2.50 hours of general nursing care per day for each skilled care patient and 1.75 hours for each intermediate care patient. We analyzed in each ward the number of general

nursing care hours Kane provided skilled and intermediate care patients on all shifts between February 15 and 28, 1976. Our analysis showed the following:

| | Average number of hours of general nursing care per day | |
|---|---|---|
| | Required | Provided |
| Skilled care patients: | | |
| Tower complex | 2.50 | 2.21 |
| Convalescent areas | 2.50 | 2.27 |
| Female infirmary | 2.50 | 1.86 |
| Male infirmary | 2.50 | 2.16 |
| Intermediare care patients: | | |
| Female infirmary | 1.75 | 1.40 |
| Male infirmary | 1.75 | 1.19 |

In June 1976, the State revoked Kane's license to operate and issued a provisional license on the grounds that Kane did not meet the State's minimum requirements for the number of hours of general nursing care for skilled and intermediate care patients. In February 1977, a Kane official told us the provisional license had been extended based on a reinspection of Kane in December 1976. Kane further stated that the patient care nursing hours issue has been resolved by a slow progressive increase in staff and a slight decrease in the number of patients serviced so that Kane was within 5 percent of being fully staffed to meet all requirements.

## RETIREMENT BENEFITS FOR CERTAIN PART-TIME EMPLOYEES

At the time of our review, Kane employed seven doctors on a part-time basis. Since Kane did not have written contracts with them, there was no criteria to judge whether these part-time doctors met their commitments to Kane or Kane to the part-time doctors.

Timesheets kept at the work stations showed that the part-time doctors worked less than 40 hours a week. However, other records in the payroll department listed the part-time doctors as employees working 40 hours a week. Kane officials told us that payroll records were adjusted to show the part-time doctors as full-time employees in order for them to qualify for Allegheny County retirement benefits after 8 years of employment at Kane. We were

told that this procedure was followed in order to get doctors to work at Kane on a part-time basis since the pay by itself was not adequate and the added inducement of a county pension was necessary. On the basis of actual hours worked for the entire year of 1974, three doctors were paid average hourly rates of $65.32, $49.45, and $32.35.

To meet the minimum length-of-service criteria for the Allegheny County retirement system, employees must have been employed full time for 8 years or for the part-time equivalent of 8 years. Since a full-time employee works 40 hours per week, then a part-time employee who works 20 hours per week would have to work 16 years to work the equivalent of 8 years full time. In each year, the 20-hour-per-week employee would earn 0.5 years of service creditable to retirement. If the part-time doctors were held to the same eligibility standards that all other participating part-time employees adhere to, during 1974 three doctors whose timesheets we examined would have earned creditable service of 0.106, 0.084, and 0.126 years each rather than a full year each.

At Kane, some part-time employees are given the option of participating in the retirement plan or not as they choose, even though it is mandatory for all. 1/ Depending on salary level, both full-time and participating part-time employees pay from 5 to 10 percent of their gross salaries into the retirement fund with the county matching employee contributions dollar-for-dollar. Since the part-time doctors, like any other part-time employees, must participate in the retirement plan and since contributions depend on salary and not hours worked, Medicaid reimbursement of the county's contribution to the retirement fund is proper and does not represent an overpayment by Medicaid.

Pennsylvania statute assigns to the directors of the Retirement Board of Allegheny County the responsibility of defining eligibility for retirement. We asked an official of the retirement board whether or not the board was aware of and approved of Kane's reporting the part-time doctors as full-time employees. This official indicated he was not aware of the practice and was not prepared to comment

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1/According to a retirement board official, new part-time employees may waive participation for the first 6 months of part-time employment. After that, participation is mandatory.

on it at that time. Kane's personnel regulations acknowlege that the Board is the proper agency to make eligibility determinations.

In our opinion, Kane and the part-time doctors should have written contracts or other suitable written agreements to spell out their mutual responsibilities. If it is deemed necessary to provide these part-time doctors with retirement benefits on a basis ordinarily applicable only to full-time employees, this provision should be made a part of the contract. Furthermore, we believe that Kane should get the written concurrence of the Retirement Board of Allegheny County if it is to offer pension benefits to certain employees on a basis different from other hospital employees.

In February 1977, Kane officials supplied us with copies of letters of understanding between Kane and two of the three part-time doctors mentioned above. All areas of concern noted above are covered by these letters of understanding except for pension benefits. In commenting on this matter, Kane indicated that the retirement board would be asked to resolve the question of retirement credits. Also, according to Kane's Executive Director, the practice of reporting the part-time doctors as full-time employees was stopped during the fall of 1976. The letters of understanding call for the two part-time doctors to work an average of 16 hours per week. At that rate, each part-time doctor would earn creditable service for retirement of 0.40 years per calendar year.

## CHAPTER 5

## SOLICITATION OF FAMILY CONTRIBUTIONS

Kane solicited contributions from relatives of certain patients and the amounts obtained were used to reduce Medicaid's cost of caring for these patients. The Federal Government and Allegheny County shared in this cost reduction.

### FAMILY CONTRIBUTIONS

Federal regulations do not prohibit nursing homes from seeking financial contributions to help defray the cost of caring for patients. However, Federal regulations (45 CFR 248.10(c)(5)) provide

> "No person unrelated to the applicant or recipient is held financially responsible for him; nor is any condition of eligibility imposed that holds a relative responsible who is not the spouse of the individual who needs medical care or service, or the parent of such individual, who is under 21, or is blind, or is permanently and totally disabled."

According to State regulations

> "Certain relatives not living with the applicant group are obligated under the Support Law to provide for their kin if they are financially able. For Medical Assistance, these relatives are spouses and parents (natural or adoptive) of unemancipated minor children."

On March 15, 1976, the State Department of Public Welfare issued a clarification of policy memorandum which said in part

> "The adult children or spouse of an eligible recipient may not be contacted, solicited, or requested to supplement a Medical Assistance payment. A Medical Assistance payment, whether or not it covers the full cost of care, constitutes full payment by the Department on behalf of a recipient. Adult children may not be contacted for such financial support under

any circumstances for a person who is currently eligible or has filed a pending application for Medical Assistance.

"Adult children and other relatives and friends of a patient may make voluntary contributions to a facility if offered freely under their own volition. * * * Such contributions will be considered income which reduces the Medical Assistance payment."

Kane solicited contributions from relatives of certain patients. The contributions were used to reduce the Federal and Allegheny County shares of the cost of Kane patients' care and not as a supplement to the Medical Assistance payment. During May 1976, Kane received contributions of about $4,700 for 106 patients. Most of the contributions were from sons and daughters of patients and were considered by Kane officials to be voluntary.

Before a patient is admitted to Kane, the patient or the patient's representative completes a preadmission application. One section of the application asks for income information about members of the patient's immediate family. If Kane believed the income information indicated one or more members of the family might be willing to make a contribution on a 1-time or continuing basis, Kane contacted the family member(s) to determine if they would contribute to the cost of caring for the patient. According to a responsible Kane official, the persons solicited were told that the contribution was voluntary and did not affect when or whether a patient was admitted and, once admitted, the kind of care the patient received.

We interviewed five people in June 1976 who were contributing to a Kane patient's care. All persons interviewd stated they felt that the quality of care their relative received at Kane was not dependent upon their contributions. However, contributors may not be fully advised by Kane that contributions are voluntary since none of the five contributors was aware that under Federal regulations they were not obligated to make contributions and two said they had felt pressured to contribute. Kane generally sent its regular contributors monthly reminders of the promised contributions.

## CONCLUSIONS

Kane Hospital properly credited the Medicaid program for contributions from relatives of patients. It did not appear to us, however, that Kane representatives had fully informed the five relatives we interviewed that contribu tions are supposed to be voluntary. In commenting on this matter in February 1977, Kane indicated that it no longer bills patients' families for services rendered. According to a Kane official, the "billings" referred to were the monthly reminders of the promised contribution.

# Allegheny County Institution District

*Executive and Administrative Officers*

JIM FLAHERTY
CHAIRMAN

Thomas J. Foerster Robert N.Peirce, Jr.

STEPHEN W. LUMHARDT
Executive Director

JOHN J. KANE HOSPITAL
VANADIUM ROAD, PITTSBURGH, PENNSYLVANIA 15243. TELEPHONE 923-2000


February 18, 1977

Mr. Gregory J. Ahart, Director
United States General Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

The enclosed is our formal response to the draft of your report on Kane Hospital as presented to us for comment. Various appendices have been previously submitted to your staff and are accompanying this letter to support the positions we are taking.

1. We appreciate the fact that your staff has verified that all employees are properly working at Kane Hospital and can assure you that this verification continues.

2. We appreciate the fact that you have pointed out that the State has improperly administered their own Medicaid plan and thus have not allowed us in the past to bill them for co-insurance and deductible items as called for in the Federal Health Insurance Regulations. We are pleased to see that the Commonwealth has promulgated regulations specifically correcting this error. We have also instituted practices which will completely eliminate improper utilization of patient funds to pay for services covered by the Medicare and/or Medicaid Program. Previous confusion at all governmental levels about this procedure has been clarified for us and we have subsequently changed our own internal practices to conform with all applicable laws.

3. We have accepted the requirement that patients' funds should be administered by independent fiscal agents and that a proper report of their individual accounts should be available. Negotiations with local financial institutions are in process and we are confident that by March 15, 1977 arrangements for the redistribution and accounting of each patients' monies will be in place.

ALLEGHENY COUNTY INSTITUTION DISTRICT



4. We have eliminated all billing to patients' families for services rendered at Kane since such billing is illegal under present Medicaid laws and regulations.

5. We do not believe that duplicate billing by us has taken place to the Medicare and Medicaid Programs. In the absence of proper documentation for previous years's cost reports it is impossible for us to completely verify the multiple billing practices which would show that total revenues and total expenditures were completely in order and within the law and regulations. We are confident, however, that no erroneous payments were made from patient funds but that any payment problems were to the detriment of the County taxpayers' dollar and not to Federal, State or patient monies.

6. The accumulation of interest in patient accounts is still to be resolved through proper involvement of the courts and the Commonwealth of Pennsylvania as it relates to escheat laws. No decision has been made up until the present time, although the procedures mentioned above will assure proper distribution from this point forward.

7. All part-time employees are now functioning either as properly salaried and/or with contracts or appropriate agreements as to working relationship. The problem of retirement credits must be resolved by the Allegheny County Retirement Board and they will be asked to do so.

8. The patient care nursing hours issue has been resolved by a slow progressive increase in staff and a slight decrease in number of patients served daily. We were 100% deficient in the Spring of 1976 and we are now within 5% as of this date of being fully staffed to meet all requirements. In fact, on many shifts we have greatly exceeded the total nursing hours required.

Lastly, let me thank you for the cooperation and interest extended by your staff in our attempt to clarify the Kane operation and our relationship with State and Federal programs.

Sincerely,

ALLEGHENY COUNTY INSTITUTION DISTRICT

Stephen W. Lenhardt
Executive Director

SWL/imh

cc: Mr. Edward G. Herron
Mr. Edward Murphy

 APPENDIX II

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
HARRISBURG

FRANK S. BEAL
SECRETARY

TELEPHONE NUMBER
787-2600, 787-3600
AREA CODE 717

February 10, 1977

Mr. Gregory J. Ahart
Director
United States General Accounting Office
Human Resources Division
Washington, D. C. 20548

Dear Mr. Ahart:

This will refer to the GAO draft report on Medicaid Payments at John J. Kane Hospital, Allegheny County, Pennsylvania.

The following comments are made on the contents of the draft report:

1. Page 3a - Paragraph 3, "Relationship between Medicaid and Part B of Medicare" should be clarified to refer to services of independent physicians who are not employed or compensated through the nursing home as they relate to the Pennsylvania Medicaid Program. Unlike Medicare, our Medicaid Program allows cost reimbursement for physicians who are employed or under contract with Kane Hospital. For further clarification, a separate section should be added to page 4a covering Medicare Part A coverage as a third party resource. Pennsylvania requires that a nursing home bill Medicare Part A for the allowable per diem reimbursement prior to any claim for payment under Medicaid.

Pages 3a, 4, and 4a have little or no impact under the Pennsylvania Medical Assistance Program since we pay for physicians services as part of the per diem rate and not under Part B of Medicare.

2. Page 4a - Reference is made on page 4a to Medicaid's "reasonable charge determination"; the words "maximum allowable fees" should be used instead of "reasonable charge determination" since our payments are not based on reasonable charges.

3. Page 4a - The sample calculation implies that DPW has a maximum fee of $9.00 for a physician's office visit; it is suggested that the example show our $6.00 maximum physician office visit fee.

4. Page 14, second paragraph - Many are 65 years or older and, therefore, qualify for coverage under Part B and Part A of the Medicare Program.

5. Page 18 makes various references to Medicaid "reasonable charges" which should be changed to maximum fees.

6. Page 19, last paragraph - It is not reasonable to expect county institutions to comply with Section 7414.2 of the DPW Manual, regarding distribution of interest on patient personal account funds in State Mental Institutions. Kane Hospital and other private or county facilities do not receive or are governed by DPW general regulations. Therefore, we suggest that this paragraph be deleted.

7. Chapter II contains various references to State policy and regulations permitting excessive accumulation of patient's funds that could be applied to the cost of nursing care. This impression is inaccurate and contrary to Federal and State regulations, which permit the accumulation of patient personal funds. The statement on page 11 improperly cites savings of $400,000 annually as a reduced Federal share of Medicaid costs.

8. Chapter II also states in various places that the State is not complying with its approved State Plan by not paying for Medicare Part B Co-Insurance. Our approved State Plan through May, 1974 only obligated the Department to pay for deductibles and cost-sharing requirements not co-insurance. The pre-print State Plan filed in June, 1974 required co-insurance payments. Due to State budget limitations, the implementation of the expanded payments was delayed until January 1, 1977.

Otherwise, we do not have any other comments on the draft report and appreciate the opportunity to react to it.

Very truly yours,

Frank S. Beal

GAO note: Page numbers in this appendix may not correspond to page numbers in this final report.

APPENDIX III

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

MAR 4 1977

Mr. Gregory J. Ahart
Director, Human Resources Division
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

The Secretary asked that I respond to your request for our comments on your draft report entitled, "Need to Improve Management of Patient Monies and Medicaid Payments at John J. Kane Hospital, Allegheny County, Pennsylvania." The enclosed comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

We appreciate the opportunity to comment on this draft report before its publication.

Sincerely yours,

John D. Young
Assistant Secretary, Comptroller

Enclosure

Comments of the Department of Health, Education, and Welfare on the Comptroller General's Draft GAO Report, "Need to Improve Management of Patient Monies and Medicaid Payments at John J.Kane Hospital, Allegheny County, Pennsylvania" dated January 21, 1977, B164031(3)

GAO RECOMMENDATION:

The Secretary of HEW should require the Administrator of the Social and Rehabilitation Service to:

-- disallow Federal financial participation in the cost of nursing care due to the existence of home maintenance allowances at Kane except where the home maintenance allowance is justified according to Federal regulations.

DEPARTMENT COMMENT:

We do not concur.

The Pennsylvania Title XIX State plan effective January 1, 1974, allows $166.00 a month for maintenance of a home for an institutionalized individual without dependents who is expected to return to his or her home within six months.

The State plan does not require the certification of a physician that such individual is likely to return to the home within such temporary period. The State has failed to comply with State plan operational requirements 45 CFR 248.3(b)(4)(ii). The failure of the State to comply with these requirements in the regulations would be the basis for compliance action. The Department does not have the authority under 45 CFR 248.3(b)(4)(ii) or 45 CFR 248.4 to disallow Federal financial participation in the increased cost of nursing care due to the existence of home maintenance allowances at Kane.

The Regional Commissioner will be directed to instruct the State of Pennsylvania to take the following action to meet the requirements of the Federal regulations:

a. The State must correct its State plan operational requirements to comply with the Federal regulations which require a physician to certify that an institutionalized individual is likely to return to the home within the six month period before an allowance for home maintenance is deducted from patients' income that would otherwise be used to pay for medical care.
b. The State must insure that all facilities providing institutional care under its title XIX program comply with the requirements of 45 CFR 248.3(b)(4)(ii) and (5).

GAO RECOMMENDATION:

The Secretary of HEW should require the Administrator of the Social and Rehabilitation Service to:

-- direct the State to insure that Kane Hospital patients get the required quarterly accounting of their personal needs accounts and that Kane Hospital get proper authorizations for expenditures from those accounts.

DEPARTMENT COMMENT:

We concur.

The Regional Commissioner will be directed to instruct the State that it must insure that Kane Hospital comply with 20 CFR 405.112(k)(6) and 45 CFR 249.12(a)1(iii) which require participating facilities to maintain on a current basis a written account of each patient's personal funds.

GAO RECOMMENDATION:

The Secretary of HEW should require the Administrator of the Social and Rehabilitation Service to:

-- require Pennsylvania to pay Medicare Part B deductible and coinsurance according to its State plan.

DEPARTMENT COMMENT:

We concur.

We have been informed that Pennsylvania is making the necessary changes in its State regulations to comply with this recommendation. The Regional Commissioner will be directed to follow-up on this recommendation to insure that the State has implemented it.

GAO RECOMMENDATION:

The Secretary of HEW should require the Administrator of the Social and Rehabilitation Service to:

-- require the State, Kane Hospital, and other providers of services to Kane Hospital patients to follow proper Medicaid billing procedures.

The Secretary of HEW should require the Administrator of the Social and Rehabilitation Service to:

-- assure that collections from Medicaid patients at Kane Hospital for Medicare Part B services cease and that restitution be made to living patients and the issue of restitution to discharged patients and the estates of deceased patients be dealt with according to Pennsylvania law.

DEPARTMENT COMMENT:

We concur.

The Regional Commissioner will be directed to instruct the State to:

1. Instruct Kane Hospital to immediately stop making payments out of patients personal accounts for the following:
   a. patients' services which are covered by and payable by either the Medicare Part B or the State Medicaid program or both,
   b. patients' Medicare Part B deductible and coinsurance which are payable by the Medicaid program, and
   c. amounts in excess of Medicare Part B prevailing reasonable charge determinations which are not payable by patients or either program.

2. Instruct the Kane Hospital to have all providers of medical care and services to Kane Hospital patients follow proper billing procedures:
   a. Bills for medical care and services covered by Medicare must be submitted to the Medicare intermediary for payment.
   b. Bills for Medicare Part B deductibles and coinsurance must be submitted to the State Medicaid Agency for payment.
   c. Bills for medical care and services provided under the State Medicaid plan and not covered by Medicare must be submitted to the State Medicaid Agency for payment.

3. Instruct the Kane Hospital to:
   a. restore to patients living in the hospital the funds spent from their personal accounts for:
      (1) medical care and services covered by Medicare and Medicaid
      (2) costs of services in excess of reasonable charge determinations which neither the Medicare nor the Medicaid programs would pay.
   b. make restitution to discharged patients and the estates of deceased patients in accordance with the Pennsylvania law for funds spent from these patients personal accounts for (1) and (2) in paragraph a. above.

GAO RECOMMENDATION:

The Secretary of HEW should require the Administrator of the Social and Rehabilitation Service to:

-- assure that monies earned through the investment of patients' funds are fairly distributed.

APPENDIX III

DEPARTMENT COMMENT:

We concur.

The Regional Commissioner will be directed to discuss with the State the issue of having Kane distribute on an equitable basis to patients any monies earned on patients' deposited funds. Presently there are no Federal regulations covering this issue. However, the matter of issuing regulations is under consideration and this finding will be taken into account when regulations are issued.

GAO RECOMMENDATION:

The Secretary of HEW should require the Administrator of the Social and Rehabilitation Service to:

-- direct the State to offset Medicare Part B payments for facility based physician services against Kane Hospital's Medicaid reimbursement for the cost of those services.

The Secretary of HEW should require the Administrator of the Social and Rehabilitation Service to:

-- recover the Federal share of Medicaid overpayments to Kane Hospital.

DEPARTMENT COMMENT:

We concur.

The Regional Commissioner will be directed to recompute the amount which Kane Hospital should have received from the State Title XIX Agency for the years 1972 forward for Medicaid patient care and to disallow any overpayments which occurred because the amounts received by Kane from Medicare for facility based physician services were included in the Medicaid patient care per diem charges. The State will be instructed to have Kane Hospital correct the calculation of the Medicaid costs so that in the future this overclaim by the State will not be repeated.

GAO RECOMMENDATION:

That the Secretary require the Administrator of SRS and the Commissioner of SSA to provide for the exchange of audit information between the Medicare intermediary and the State Auditor General.

DEPARTMENT COMMENT:

SSA, in cooperation with SRS, has worked hard over the past several years to carry out a common Medicare/Medicaid audit program with all Title XIX State agencies to share in the cost and in the direction of the audits needed for both programs. During the past four years, the Philadelphia Regional Office has made extensive efforts to work out a common audit agreement with the Auditor General of Pennsylvania, but those efforts have not been successful. We still believe that such an agreement and the resulting common Medicare/Medicaid audits would be beneficial to the State and to the Medicare and Medicaid programs.

Medicare audited cost reports are available to the States under the Freedom of Information Act. We would point out, however, that the simple exchange of Medicare audited cost reports and related information, which GAO recommends, generally would not respond to many of the Title XIX needs since Medicare audits do not cover in detail all of the cost centers that apply to Medicaid-e.g., pediatrics, obstetrics, etc.

OTHER MATTERS DISCUSSED IN THE GAO REPORT

The report should make it clear that John J. Kane Hospital is not certified as a Medicare hospital, but is only certified for Medicare as a Skilled Nursing Facility (SNF) which includes 550 of Kane's 2,112 total beds. The Medicare intermediary, the Pittsburgh Blue Cross Plan, has audited Kane's SNF cost reports through December 31, 1975--the calendar year 1976 cost report is not yet due. All of the Medicare audits have been limited in scope based on the intermediary's determination of the extent of verification needed to assure the accuracy of the Medicare SNF costs claimed.

Thus, Kane is eligible for Medicare Part A reimbursement only with respect to its SNF services. Under Part B of Medicare, Kane is eligible for reimbursement for the professional component of hospital-based physicians' salaries. The Medicare intermediary is responsible for the development of the facts supporting this reimbursement and for coordinating the determination with the Medicare Part B carrier--Pennsylvania Blue Shield. The carrier reimburses Kane for these services on the basis of submitted bills. Our records indicate that Medicare reimbursement in both Part A and Part B is current and proper.

APPENDIX IV

## RELATED GAO REPORTS ISSUED SINCE 1972

| Report title | Number | Date issued |
|---|---|---|
| State Audits to Identify Medicaid Overpayments to Nursing Homes | HRD-77-29 | 1-24-77 |
| Improvements Needed in Managing and Monitoring Patients' Funds Maintained by Skilled Nursing Facilities and Intermediate Care Facilities | MWD-76-102 | 3-18-76 |
| Increased Compliance Needed with Nursing Home Health and Sanitary Standards | MWD-76-8 | 8-18-75 |
| Improvements Needed in Medicaid Program Management Including Investigations of Suspected Fraud and Abuse | MWD-75-74 | 4-14-75 |
| Need to More Consistently Reimburse Health Facilities Under Medicare and Medicaid | B-164031(4) | 8-16-74 |
| Better Use of Outpatient Services and Nursing Care Bed Facilities Could Improve Health Care Delivery to Veterans | B-167656 | 4-11-73 |
| Problems in Providing Guidance to States in Establishing Rates of Payment for Nursing Home Care Under the Medicaid Program | B-164031(3) | 4-19-72 |
| Summary of Reviews of Planning, Construction, and Use of Medical Facilities at Selected Locations | B-167966 | 3- 7-72 |

## PRINCIPAL HEW OFFICIALS RESPONSIBLE FOR THE ADMINISTRATION OF ACTIVITIES DISCUSSEL IN THIS REPORT

| | Tenure of office From | To |
|---|---|---|
| SECRETARY OF HEALTH, EDUCATION, AND WELFARE: | | |
| Joseph A. Califano, Jr. | Jan. 1977 | Present |
| David Mathews | Aug. 1975 | Jan. 1977 |
| Caspar W. Weinberger | Feb. 1973 | Aug. 1975 |
| Frank C. Carlucci (acting) | Jan. 1973 | Feb. 1973 |
| Elliot L. Richardson | June 1970 | Jan. 1973 |
| ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION: | | |
| Don I. Wortman (acting) | Mar. 1977 | Present |
| ADMINISTRATOR, SOCIAL AND REHABILITATION SERVICE: | | |
| Don I. Wortman (acting) | Jan. 1977 | Mar. 1977 |
| Robert Fulton | June 1976 | Jan. 1977 |
| Don I. Wortman (acting) | Jan. 1976 | June 1976 |
| John A. Svahn (acting) | June 1975 | Jan. 1976 |
| James S. Dwight, Jr. | June 1973 | June 1975 |
| Francis D. DeGeorge (acting) | May 1973 | June 1973 |
| Philip J. Rutledge (acting) | Feb. 1973 | May 1973 |
| John D. Twiname | Mar. 1970 | Feb. 1973 |
| COMMISSIONER, MEDICAL SERVICES ADMINISTRATION: | | |
| M. Keith Weikel | July 1974 | Present |
| Howard N. Newman | Feb. 1970 | July 1974 |
| COMMISSIONER, SOCIAL SECURITY ADMINISTRATION: | | |
| James B. Cardwell | Sept. 1973 | Present |
| Arthur E. Hess (acting) | Mar. 1973 | Sept. 1973 |
| Robert M. Ball | Apr. 1962 | Mar. 1973 |