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Report to Governor, Ohio; Speaker of the House, Ohio: House of Representatives; President, Ohio: Senate; by Elmer B. Staats, Comptroller General.

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Ohio began its medicaid program on July 1, 1966. During 1967, the State spent $50.6 million to provide medical services to a monthly average of about 300,000 eligible individuals. In its 11-year existence, Ohio's medicaid program costs increased tenfold, and the number of eligibles increased 143%. Over the same period, medicaid costs increased about 1,500% nationwide. Findings/Conclusions: Ohio has limited many of its benefits in efforts to contain the large yearly increases in medicaid costs, but these limitations have not always resulted in sufficient savings to balance medicaid budgets. The State has occasionally tried to temporarily cut medicaid benefits and reimbursement rates for providers; these efforts have been only partially successful. Ohio used incorrect eligibility criteria and procedures which resulted in about 26,000 ineligibles receiving medicaid, and many who should have been eligible were denied benefits. Reports which were used to set nursing home payment rates included unallowable costs which inflated payments to nursing homes. While the State was overpaying nursing homes for services they provided, Ohio's ceilings on nursing home payments were inadequate for the costs incurred by patients needing skilled nursing. Because of a lack of controls, Ohio paid some providers in excess of the amounts allowed for Federal sharing. Recommendations: The State of Ohio should revise its medicaid eligibility requirements and determination procedures to comply with Federal regulations. It should: assess the usefulness of medicaid eligibility requirements for allowable personal resources, strengthen the control procedures developed to ensure correction of errors, and examine the administration of medicaid and other welfare programs by county welfare departments. The

State should also: improve the medicare buy-in program, improve control of medicaid extensions for terminated AFDC recipients, obtain Federal financial participation for paid medical expenses of general relief recipients subsequently found eligible for medicaid, take action to minimize excessive medicaid payments by establishing controls to prevent payments to practitioners exceeding the upper limits, audit nursing homes whose cost reports are used to develop cost ceilings, and assess its audit capability to determine what it needs to comply with the Federal 1980 field audit deadline. (RRS)

8062

REPORT BY THE

Comptroller General

OF THE UNITED STATES

Improved Administration Could Reduce The Costs Of Ohio's Medicaid Program

Millions of dollars could be saved in Ohio's Medicaid program by

--increasing payment rates for skilled nursing facilities so that they will accept patients who presently are forced to remain in more expensive hospital beds and

--improving the administration of programs related to eligibility determinations.

GAO identified weaknesses in the procedures used to (1) set provider reimbursement rates, (2) control the use of medical services, and (3) process claims for payment.

Failure to follow appropriate administrative practices has resulted in several successful lawsuits against Ohio which hampered the State's efforts to control Medicaid costs.

HRD-78-98

OCTOBER 23, 1978

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

B-164031(3)

To the Governor of Ohio, the
Speaker of the Ohio House of
Representatives, and the
President of the Ohio Senate

This report presents the results of our comprehensive review of Ohio's Medicaid program. The report identifies several areas of program administration which could be improved to help control the State's Medicaid program. The Ohio Department of Public Welfare which administers the Medicaid program has accepted our recommendations and their implementation should prove beneficial to program administration. To fully implement our recommendations several changes to State law will be necessary. The Department has informed us that it has requested or will request these legislative amendments.

We made the review at the request of the Governor of Ohio, the Ohio Legislature, and the Ohio congressional delegation.

Copies of the report are being sent to the Director of the Ohio Department of Public Welfare, the Ohio Legislative Budget Office, the Ohio Office of Budget and Management, the Auditor of Ohio, and other interested parties.

Sincerely yours,

Comptroller General
of the United States

COMPTROLLER GENERAL'S REPORT TO THE STATE OF OHIO

IMPROVED ADMINISTRATION COULD REDUCE THE COSTS OF OHIO'S MEDICAID PROGRAM

D I G E S T

Ohio's Medicaid program was not complying with Federal and/or its own policies. It used incorrect eligibility criteria and procedures which resulted in about 26,000 ineligibles receiving Medicaid and many who should have been eligible were denied benefits. (See pp. 9 and 11.) Ohio could save several million dollars by improving programs related to eligibility determinations. For example:

--About $1 million in cash assistance payments and an undetermined amount of Medicaid funds could have been saved by expediting the recipient hearing process. (See p. 41.)

--About $84,000 a year in State and county funds in Hamilton County alone could have been saved by arranging to obtain Federal sharing in the cost of medical services provided to general assistance recipients subsequently determined to be eligible for Medicaid. (See p. 42.)

In the eligibility determination area, the State has implemented our proposal to automatically terminate 4-month Medicaid extension cases which should save about $2.75 million a year.

GAO found that reports which were used to set nursing home payment rates included many unallowable costs. This inflated payments to nursing homes. GAO found that 25 percent of cost items it audited in 10 nursing homes were unallowable. Ohio's desk audit procedures disallowed only 60 percent of these unallowable costs. (See ch. 7.)

While the State was overpaying nursing homes for the services they provided, GAO found that Ohio's ceilings on nursing home payments were inadequate to pay for the services needed by recipients who require skilled nursing. This resulted in these recipients remaining in hospitals and the needless expenditures of millions of dollars each year. (See ch. 12.)

Because of lack of controls, Ohio had paid some providers in excess of the amounts allowed for Federal sharing. Also, because of the methods used to set fee schedules for providers, some types of Medicaid benefits may not have been readily available to recipients. (See ch. 6.)

Ohio's program to control the utilization of institutional services was designed primarily to prevent a reduction in Federal sharing in the costs of long-term care. Ohio was foregoing many of the quality of care and cost containment benefits of institutional utilization review. (See ch. 10.)

The State's program of utilization control and abuse detection for ambulatory services was hampered by a lack of specific criteria as to what constitutes misuse of the Medicaid program. GAO tested a program which would both help assure quality and provide more specific criteria and believes a similar program could be beneficially used by Ohio. (See ch. 9.)

Ohio's claims processing system lacked edits which it should have had and contained improperly programed edits. Both of these conditions resulted in improper claims being paid when GAO tested the system. New computer programs added to the claims processing system or changes to existing programs were not properly controlled or tested leaving the system open to errors and to employee fraud. (See ch. 8.)

The preventive health care program for children eligible for Medicaid was not operating as effectively as it could have. (See ch. 13.)

GAO is making a number of recommendations to overcome the problems identified in the review.

AGENCY COMMENTS

The State Medicaid agency accepted GAO's recommendations and said it was in the process of implementing or had already implemented many of them and was seeking legislative authority or appropriations necessary to implement others. (See app. I.)

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I Letter dated April 28, 1978, from Ohio Department of Public Welfare 147

ABBREVIATIONS

AFDC	Aid to Families with Dependent Children
EOMB	explanation of Medicaid benefits
EPSDT	early and periodic screening, diagnosis, and treatment
GAO	General Accounting Office
HCFA	Health Care Financing Administration
HEW	Department of Health, Education, and Welfare
HMO	Health Maintenance Organization
ICF	intermediate care facility
MAR	Management and Administrative Reports subsystem
MMIS	Medicaid Management Information System
PACE	Physician Ambulatory Care Evaluation program
PSRO	Professional Standards Review Organization
SNF	skilled nursing facility
SSA	Social Security Administration
SSI	Supplemental Security Income
SUR	Surveillance and Utilization Review

CHAPTER 1

INTRODUCTION

In August 1976 the Ohio Legislature enacted a bill which included a section calling on the Ohio congressional delegation to request us to make a comprehensive audit of the State's Medicaid program. Subsequently, the Co-chairman of the Legislature's Joint Select Committee on Welfare sent a letter to Ohio's members of Congress asking them to request our review, which 19 of them did. The Governor of Ohio also asked us to make a comprehensive review of the State Medicaid program.

Normally, we would have declined to make such an audit because our limited resources must be expended in the context of our basic statutory responsibility to be directly responsible to the Congress for making independent audits and evaluating Federal programs and to provide broad coverage to various national issue areas in addition to health, of which Medicaid is only a part. On the other hand, we were well aware of the rising costs of Medicaid and the resulting financial burden being borne by the States in providing health care to their needy citizens. We were also aware of the problems in controlling these costs without arbitrarily withdrawing or limiting needed services. We were concerned with these problems and wanted to help the States in dealing with them.

Because of our desire to be of assistance to the States in this important area, we decided that we should accept Ohio's request. At the same time, we notified the cognizant congressional committees that we did not intend to devote substantial staff resources to any additional requests for comprehensive reviews of State Medicaid programs, at least until the Ohio review was completed and we and the cognizant congressional committees had an opportunity to assess the benefits of this evaluation.

The Ohio Legislative Budget Office, the Ohio Legislative Services Commission, the Ohio Office of Budget and Management, and the Auditor of Ohio provided staff to assist us in this review.

THE MEDICAID PROGRAM

Medicaid is a Federal/State program under which the Federal Government pays from 50 to 78 percent of State costs of providing health services to the poor. Medicaid was authorized by title XIX of the Social Security Act which was established by the Social Security Amendments of 1965 (Public Law 89-87) and became effective on January 1, 1966. Medicaid consolidated and expanded the medical assistance provisions of the cash assistance programs for the aged, blind, disabled, and families with dependent children.

The States are responsible for designing, establishing, and operating their Medicaid programs under the provisions of title XIX and regulations of the Department of Health, Education, and Welfare (HEW). The law requires the States with Medicaid programs to provide inpatient and outpatient hospital services; laboratory and X-ray services; physician services; skilled nursing facility services; home health services; family planning services; and early and periodic screening, diagnosis, and treatment services for eligible persons under 21 years of age. HEW regulations require the States to provide transportation to and from medical providers. Title XIX also permits the States' Medicaid programs to cover any other medical or remedial service recognized under State law.

Medicaid can cover two groups of persons. The first group is the "categorically needy" which includes individuals who receive, or are eligible to receive but have not applied for, cash assistance under either the Supplemental Security Income program (SSI) or the Aid to Families with Dependent Children program (AFDC). The categorically needy must be covered under Medicaid, except that a State can choose to use more restrictive eligibility criteria for aged, blind, and disabled persons than SSI's criteria which became effective in January 1974. However, the criteria cannot be more restrictive than the criteria used by the State in January 1972. Ohio has elected to use this option. (See p. 9 for a more detailed discussion.)

The second group is the "medically needy" which includes persons whose income and/or resources are too high to receive cash assistance but are insufficient to pay for their medical care. Ohio has not chosen to cover the medically needy.

State Medicaid plans list the eligibility criteria for Medicaid; the amount, duration, and scope of services covered; and the methods the State will use to administer the program. The Health Care Financing Administration (HCFA) of HEW approves, for Federal cost sharing, State plans which meet Federal requirements. HCFA also monitors State Medicaid operations to ensure that they conform to Federal requirements and the approved State plan.

OHIO MEDICAID PROGRAM

Ohio began its Medicaid program on July 1, 1966. During 1967 Ohio spent $50.6 million to provide medical services to a monthly average of about 300,000 eligibles. During the fiscal year ended June 30, 1977, the cost of Ohio's Medicaid program was $558.5 million and covered, on the average, 730,000 persons each month. Thus, in its 11-year existence Ohio's Medicaid program costs had increased tenfold, and the number of eligibles had increased 143 percent. Over the same period, Medicaid costs have increased about 1,500 percent nationwide.

Program data regarding (1) the groups covered, (2) the benefits provided, and (3) provider participation follows.

Groups covered

Title XIX requires States to cover certain groups of persons, basically cash assistance recipients, and allows coverage of other groups at the State's option. Ohio provides Medicaid services to all its AFDC recipients. It uses eligibility criteria more restrictive than SSI's to determine eligibility of SSI recipients. Because this option is used, Ohio allows aged, blind, and disabled recipients to deduct their medical expenses from their income when determining eligibility for Medicaid. These people become eligible once their medical expenses have lowered their income below the Medicaid eligibility level.

In addition to covering those groups mandated by Federal law, Ohio has elected to cover

--persons in a medical facility who if they left the facility, would be eligible for AFDC or SSI,

--unborn children of AFDC recipients and AFDC families with unemployed fathers, and

--persons who would be eligible for AFDC if their work-related child care costs were deducted from income.

As of June 30, 1977, the number of Medicaid eligibles totaled 719,000--151,000 recipients in the SSI category and 568,000 recipients in the AFDC category.

Benefits provided

Ohio has chosen to provide a wide range of optional benefits. The table below shows the costs and types of benefits provided during the year ended June 30, 1977.

Mandatory	Cost	Percent of total
Inpatient hospital services	$190,590,000	34.1
Physician services	62,580,000	11.2
Outpatient hospital services	40,370,000	7.2
Skilled nursing facility services	13,440,000	2.4
EPSDT services (note a)	2,280,000	0.4
Family planning services	1,450,000	0.3
Laboratory and X-ray services	1,260,000	0.2
Home health services	900,000	0.2
Subtotal	$312,870,000	56.0
Optional		
Intermediate care facility services	$168,960,000	30.2
Prescribed durgs	45,570,000	8.2
Dental services	13,740,000	2.5
Other practitioners services (note b)	7,860,000	1.4
Medical supplies and ambulances	5,490,000	1.0
Clinic services	4,010,000	0.7
Subtotal	$245,630,000	44.0
Total	$558,550,000	100.0

a/Early and periodic screening, diagnosis, and treatment.

b/Includes optometric, psychological, podiatric, chiropractic, private duty nursing, physical therapy, speech therapy, and occupational therapy services.

Provider participation

Persons eligible for Medicaid in Ohio can receive services from institutions, groups, and individuals who have signed provider agreements. A provider agreement is a contract between the Ohio Medicaid program and the provider of medical services who agrees to abide by program rules and regulations. As shown in the following table, 26,921 providers had agreed to participate in the program as of July 1977.

	Number and location of providers		
	Ohio	Out of State	Total
Physicians	11,294	2,086	13,380
Dentists	3,222	113	3,335
Other practitioners	3,034	100	3,134
Pharmacies	2,151	95	2,246
Hospitals	234	1,007	1,241
Ambulances	926	87	1,013
Supplies and equipment	922	74	996
Long-term care facilities	963	4	967
Clinics	364	4	368
Laboratory and X-ray	109	24	133
Home Health agencies	103	5	108
Total	23,322	3,599	26,921

While these figures indicate wide provider participation among physicians and other practitioners, they are somewhat misleading. Some participating providers received no payments during the year ended June 30, 1977. The bulk of the payments for services provided to recipients in the SSI category went to relatively few providers, as shown in the following table.

Payments to Providers in Year Ended June 30, 1977, for SSI Category Recipients

Type of service	Total payments	Providers receiving payments (note a)	Providers receiving 50 percent of the payments	
			Number	Percent of total
Physician	$15,150,000	11,483	643	5.6
Dental	1,890,000	2,557	82	3.2
Optometric	1,450,000	1,289	76	5.9
Podiatric	610,000	401	25	6.2

a/The number of providers receiving payments regardless of the recipients' aid category.

The following table shows the concentration of provider participation was even greater for Medicaid services for recipients in the AFDC category.

Payments to Providers in Year Ended June 30, 1977, for AFDC Category Recipients

Type of service	Total payments	Providers receiving payments (note a)	Providers receiving 50 percent of the payments	
			Number	Percent of total
Physician	$47,430,000	11,483	352	5.1
Dental	11,850,000	2,557	60	2.3
Optometric	3,980,000	1,289	58	4.5
Podiatric	860,000	401	13	3.2

a/The number of providers receiving payments regardless of the recipients' aid category.

These statistics show that a relatively small number of physicians and other practitioners provided the bulk of the services for Medicaid.

SCOPE OF REVIEW

Our review was directed at ascertaining the effectiveness of Ohio's management of its Medicaid program. We reviewed almost all aspects of the Medicaid program, but we

emphasized (1) the claims payment system, (2) utilization control of medical services, (3) recipient eligibility determinations, and (4) the processes used to determine provider reimbursement rates.

Our review was conducted at HEW headquarters in Washington, D.C.; the HEW regional office in Chicago, Illinois; the Ohio Departments of Public Welfare, Health, and Mental Health and Mental Retardation; local welfare offices in Franklin, Licking, Mercer, and Montgomery Counties; Professional Standards Review Organizations covering the metropolitan areas of Cincinnati, Columbus, and Toledo; the two contractors making nursing home utilization reviews; and selected medical providers.

We reviewed Federal and State legislation, regulations, guidelines, policy, and procedures relating to Medicaid. We also reviewed and analyzed reports, records, and other data pertaining to Ohio's Medicaid program and held discussions with Federal, State, and local officials responsible for administering the Medicaid program.

CHAPTER 2

INCORRECT ELIGIBILITY CRITERIA AND PROCEDURES ADVERSLY AFFECT MEDICAID PARTICIPATION

A State's Medicaid eligibility requirements largely determine how many citizens will participate and the program's cost. From January 1974 until August 1977, Ohio used eligibility requirements and procedures which conflicted with Federal law and regulations. As a result, many persons who should have been eligible for Medicaid were not and many citizens received benefits who would not have been eligible if the State's procedures were consistent with Federal regulations. In 1977 about 26,000 citizens received Medicaid even though their eligibility was questionable.

While conflicts between Ohio's eligibility criteria and Federal law and regulations have existed since January 1974, the Department of Health, Education, and Welfare did not advise the State agency to correct them until December 1975. At that time, HEW told Ohio to immediately remove a gross income limit the State agency had imposed in January 1975. Under this limit, individuals could be ineligible even if authorized deductions brought them below Medicaid's net income eligibility criteria. Despite this and subsequent directives, Ohio continued to administer its Medicaid eligibility process incorrectly until a U.S. district court ordered the State agency to stop using the gross income limit. HEW did not recognize other incorrect eligibility procedures until November 1976 when the State agency officials sought clarification of Federal policy.

In an effort to correct the errors in Ohio's Medicaid eligibility process, the State agency encountered problems with its interpretation of the provisions of State law and the wishes of the State's legislature. Consequently, a State court decision and legislative action nullified a major effort to revise the State's eligibility process, several days before implementation in July 1977. Because the State agency's revisions were not implemented, aspects of Ohio's Medicaid eligibility determination process continued to conflict with Federal regulations and needed revision.

BACKGROUND

Title XIX of the Social Security Act established the Medicaid program and provided the States with Federal grants to furnish medical assistance to individuals receiving financial assistance and others whose incomes and resources are insufficient to meet the cost of medical care. Medicaid eligibility is linked to the federally assisted Aid to Families with Dependent Children program and the Federal Supplemental Security Income program for the aged, blind, and disabled. Generally, States must cover all cash assistance recipients of these programs; however, they can limit Medicaid's coverage of SSI recipients by using more restrictive eligibility standards than those applied by SSI. States exercising this option are required by section 1902(f) of the Social Security Act to allow all aged, blind, and disabled persons the opportunity to establish Medicaid eligibility by subtracting incurred medical expenses from their income. This requirement is commonly referred to as a "spend-down" procedure. Regardless of the method employed, no State Medicaid eligibility criteria for the aged, blind, and disabled categorically needy can be more liberal than SSI's. The State's medical assistance plan, which states its Medicaid eligibility requirements, was approved by HEW for implementation in January 1974.

IMPOSED INCOME CEILING DENIES BENEFITS TO POTENTIAL ELIGIBLES

In 1973, Ohio opted to restrict its coverage of the aged, blind, and disabled to avoid an expected increase in Medicaid expenditures due to the broader scope of the SSI program. Consequently, the State agency established a spend-down program beginning in January 1974, but in January 1975 it imposed a $438 limitation on the monthly gross income an applicant or recipient could have to remain eligible for Medicaid; that is, these individuals were not permitted to spend down. As a result, persons who should have received Medicaid in Ohio did not.

HEW was not aware of Ohio's gross income restriction until May 1975, when an association of homes for the aged requested an interpretation of Federal policy. In December 1975, HEW notified the State agency that its practice of not allowing aged, blind, and disabled individuals with incomes in excess of $438 to receive Medicaid benefits after

spending down did not conform with Federal law and regulations. HEW advised the State agency that existing procedures must be modified to conform with Federal regulations. HEW explained that when States did not automatically cover SSI recipients under Medicaid, they must permit the aged, blind, or disabled to spend-down. The State agency questioned HEW's interpretation of the Federal regulations and did not remove the income ceiling.

In June 1976, while the State agency was disputing this compliance issue with HEW, a disabled individual filed a suit in a U.S. district court contesting the legality of Ohio's gross income limitation on Medicaid eligibility. The plaintiff, who was confined to a nursing home, was terminated from Medicaid when an increase in his Veteran's pension raised his income over the State's $438 ceiling. In February 1977, the court declared that Ohio's gross income ceiling did not comply with Federal law. The plaintiff was awarded court costs and the State was permanently enjoined from failing to provide Medicaid to him as long as his income, after medical expense deductions, did not exceed the State's income standard. The court denied the plaintiff's motion to certify this case as a class action yet noted in its decision:

> "* * * that the declaratory judgment aspect of this Order will require the defendents [State Agency] to modify their treatment of all those who are similarly situated in a manner not inconsistent with said declaratory judgment."

The State agency, however, did not direct the county welfare departments to allow all aged, blind, and disabled individuals to spend-down because in its opinion the U.S. district court's order did not specifically require such action. Consequently, in June 1977, nine plaintiffs brought a second suit in a U.S. district court as a class action to enforce the decision reached in the earlier case. All plaintiffs had been terminated from Ohio's Medicaid program, subsequent to the earlier decision, because their gross income exceeded the $438 limit. The court issued a temporary restraining order on behalf of the plaintiffs and their class which prohibited the State agency from using the income ceiling. The State agency advised all county welfare departments to comply effective June 7, 1977.

In November 1976, HEW and State officials met and agreed that Ohio must allow all aged, blind, and disabled individuals an opportunity to spend-down their excess income as long as the State retained eligibility requirements more restrictive than SSI's. Fearing a major increase in Medicaid expenditures if the $438 gross income ceiling was eliminated, State officials asked HEW to explain how the State might adopt SSI eligibility criteria and, thus, eliminate the need for a spend-down program. Meetings were held with Social Security Administration (SSA) officials to discuss using SSI eligibility criteria for SSI-related Medicaid applicants and recipients. Public hearings were held on the proposed revisions during February 1977, and the State agency signed a contract with SSA in March 1977. The new eligibility requirements and SSA's administration were to become effective July 1, 1977, but because of a State court order and State legislative action which prohibited the State from entering into the agreement with SSA, SSA did not assume administration of eligibility determinations.

INCORRECT MEDICAID ELIGIBILITY CRITERIA AND PROCEDURES

In November 1976, HEW found that Ohio's treatment of income and resources of Medicaid applicants who resided with their families was more liberal than SSI's, which was prohibited by Federal regulations. While Ohio restricts income and resource requirements for Medicaid eligibility to levels below SSI's levels, the State's procedures used to compute an applicant's available income and resources are more liberal than SSI's. Consequently, about 26,000 aged, blind, and disabled persons received Medicaid in Ohio who were ineligible for SSI benefits. The following example illustrates Ohio's income adjustment procedure and the correct SSI method.

A husband and wife apply for Medicaid. He is 60 years old and receives $210 a month in Social Security disability benefits. His wife is 65 years old and receives $150 a month from Social Security retirement benefits. Assuming all other eligibility factors are met, the following income determinations would be calculated.

Ohio Medicaid

Husband	$210.00		
Wife	+150.00		
	360.00		-Total income
	-146.00		-Family disregard
	$214.00	$107.00	-Prorated share (each spouse)
		-20.00	-Unearned income disregard (each spouse)
		$ 87.00	-Net countable income (each spouse)

By comparing net countable income ($87.00) to the Medicaid individual need standard of $146.00, both are eligible for Medicaid.

SSI

Husband	$210.00	
Wife	+150.00	
	$360.00	-Total income
	- 20.00	-Unearned income disregard
	$340.00	-Net countable income

By comparing net countable income of $340.00 to SSI's $284.10 couple standard, both are ineligible for SSI and would have to spend down in order to become eligible for Medicaid under Ohio's State Medicaid plan.

As shown in the example, Ohio permits disregarding $146 monthly for family expenses for an applicant who is a member of and resides with a family group. After this disregard is deducted, the remaining income is prorated (divided equally among all family members). From the prorated share a $20 unearned income disregard is deducted for personal expenses. If an applicant is working, the first $65 plus one-half of the remaining earned income is deducted instead of the $20 unearned income disregard. In contrast to Medicaid, SSI disregards only $20 if the applicant is not working or $65 plus one-half of earned income if the applicant is employed. Also, SSI does not prorate either family income or resources. As noted above, only couples and families have this advantage since a single individual would be allowed only the $20 unearned income disregard or the $65 plus one-half earned income disregard in either the Ohio Medicaid or the Federal SSI program.

To correct the eligibility compliance problems in its Medicaid program, the State agency proposed to implement a contract in July 1977 which would have had SSA determining Medicaid eligibility for SSI recipients. As a result, the State estimated about 26,000 aged, blind, and disabled Medicaid recipients would lose their benefits, and approximately 34,000 SSI recipients who previously were required to spend-down to become eligible for Medicaid because of the State's more restrictive requirements would become automatically eligible for the program.

In July 1977, the Ohio State Legal Services Association filed suit in an Ohio State court on behalf of the Medicaid recipients who would lose their benefits. The plaintiffs claimed the State agency's proposed adoption of SSI eligibility criteria, elimination of the spend-down program, and SSA determination of Medicaid eligibility conflicted with State law. On July 28, 1977, the court ruled that Ohio's contract with SSA was void because State law required county welfare workers to determine Medicaid eligibility.

At about the same time, Ohio's Legislature reaffirmed its decision to retain the State's more restrictive Medicaid eligibility requirements and State administration of the eligibility process. On August 1, 1977, the State agency rescinded all previous instructions issued to implement the contract with SSA and to revise incorrect Medicaid eligibility determination procedures. The gross income limitation for Medicaid eligibility was removed, but the incorrect procedures for determining eligibility for couples and families were not revised.

CONCLUSIONS

Ohio's Medicaid eligibility criteria for needy aged, blind, and disabled citizens implemented in 1974 were intentionally designed to restrict SSI recipients from participating as a means of controlling Medicaid costs. One provision which was added a year later, a maximum gross income ceiling, not only limited participation but did so contrary to Federal law and regulations. Some of the State's eligibility procedures were also incorrect and, as a result, many recipients who received Medicaid were ineligible.

Correcting Ohio's Medical Assistance Plan has involved concerned citizens, the State agency, HEW, the State court

system, and the Federal court system and has taken several years. Some procedures were still incorrect as late as April 1978. Much of the delay in correcting the deficiencies can be attributed to HEW's failure to recognize them and an unwillingness to insist upon prompt revisions. The State agency's dispute of HEW and Federal court interpretations of Federal law and regulations also impeded timely correction.

The State agency's major effort in July 1977 to revise Medicaid eligibility determinations and to comply with Federal regulations did not fully consider existing State statutes. Thus, several days before implementation, this plan was nullified and abandoned. Consequently, Ohio had to begin again in August 1977 to revise the State's Medicaid eligibility determination process.

RECOMMENDATION

We recommend that Ohio revise its Medicaid eligibility requirements and determination procedures to comply with Federal regulations. The State should consult with HEW on necessary revisions so that the process may be accomplished quickly and accurately.

AGENCY COMMENTS

The State Medicaid agency, in commenting on our report, said that many of its problems with eligibility resulted from unclear Federal regulations and unworkable Federal policies. The State also cited the fact that HEW had approved its State plan which included the incorrect eligibility criteria which was later disputed. The State said it would correct its eligibility deficiencies as soon as HEW tells it in writing how to do so.

We agree with the State that many eligibility rules for Medicaid are quite complex. We also agree that HEW's management of and assistance relating to the State's eligibility criteria could be improved.

CHAPTER 3

STATE EFFORTS TO CONTAIN PROGRAM COSTS HAVE BEEN HAMPERED BY ADMINISTRATIVE ERRORS

Ohio has limited many of its benefits in its efforts to contain the large yearly increases in Medicaid costs. Because these limitations have not always resulted in sufficient savings to balance Medicaid budgets, Ohio has occasionally tried to temporarily cut Medicaid benefits and reimbursement rates for providers. These efforts have been only partially successful because Ohio did not follow procedural requirements.

Ohio is currently considering and/or testing alternatives to its benefit structure and reimbursement methods which advocates claim will reduce Medicaid costs. In attempting to implement these measures, the State needs to be careful to avoid the administrative errors that have hampered past efforts.

BENEFIT LIMITATIONS TO PROMOTE ECONOMY AND CURB ABUSES

The Ohio Medicaid program has imposed several limitations on the use of benefits which are primarily designed to promote economy and curb abuses. The following are some typical examples:

--Inpatient hospital services are limited to those days determined to be medically necessary and to 60 days per spell of illness. (The period between initial hospitalization and such time as the recipient has not been in a hospital at least 60 consecutive days.)

--Office visits by a recipient to a single practitioner are limited to four a month without prior authorization.

--Drugs are limited to 5 refills which must be obtained within 6 months after the date of the original prescription.

--Prior authorization is required for many dental and vision services and types of medical supplies and equipment.

--Vision care examinations are limited to 1 per year for children and 1 every 2 years for adults.

Ohio was considering, but as of April 1978 had not implemented, other restrictions including:

--Establishing a copayment system under which individual payments to providers of optional benefits, such as vision, dental, foot care, and prescribed durgs, would be reduced by amounts ranging from $0.50 to $8.00.

--Requiring second opinions on selected surgeries identified as often being unnecessary, such as tonsilectomies and hysterectomies. 1/

--Requiring a recipient identified as a program abuser or overutilizer to receive care from only one physician of the recipient's choice.

LONG-TERM CARE FACILITY PAYMENT REDUCTION NOT IMPLEMENTED IN ACCORDANCE WITH STATE LAW

Claiming a lack of sufficient funds, the Ohio Medicaid program implemented in July 1975 a formula for reimbursing long-term care facilities at rates lower than those authorized by State law. This formula was used for only 5 months because the program reported that extra funding had become available by December 1975 which permitted the reimbursement rate cuts to be canceled.

Ohio law allowed the reimbursement formula for long-term care facilities to be revised, provided certain procedures were followed. A group of facility owners sued the State in September 1975 alleging that the Ohio Medicaid program failed to follow these procedures. In March 1977, a State court of appeals reversed a lower court decision which had upheld the action of the Ohio Medicaid program. Specifically, the court of appeals found that:

1/In October 1977, HEW also emphasized obtaining a second opinion before elective surgery is performed.

--The program did not obtain controlling board (a panel of six members of the Ohio legislature and a member of the executive branch) approval before the formula was implemented and without such approval, implementation could not be legal.

--The formula used in implementing the reductions affected some facilities more than others, and thus, did not meet the State requirements for a pro rata reduction.

The State appealed this decision to the Ohio Supreme Court. On June 21, 1978, the court ruled that the State had to pay the nursing homes the reimbursement rate authorized by the legislature. The decision required the State to make retroactive payments to the facilities which could run as high as $14 million.

POTENTIAL SAVINGS THROUGH REVISION OF BENEFIT PROGRAMS AND REIMBURSEMENT METHODS

Ohio is studying alternatives to its current benefit program and reimbursement methods that may eventually help to limit Medicaid costs. Three of the alternatives being considered are discussed below.

Prospective reimbursement

Ohio is considering a prospective reimbursement method for paying hospitals for services provided to Medicaid recipients. Prospective reimbursement entails establishing before the applicable period the rate the provider will be reimbursed. Proponents of prospective reimbursement believe that the rewards and penalties of such a system will motivate hospitals to allocate resources more efficiently without compromising the quality of their services.

A HEW study of seven operating prospective reimbursement systems completed in 1976 concluded that:

--Prospective reimbursement systems seem to slow the rate of increase in hospital costs.

--The impact of prospective payment is not always the same; some systems contain health care costs more effectively than others.

--The amount of savings that can be attributed to prospective reimbursement is small relative to the trend in total health cost increases.

--No evidence exists that prospective reimbursement causes quality of care to deteriorate.

An advisory group to the State Legislature reported in April 1977 that prospective reimbursement was a feasible means for reducing the rate of increase in hospital costs. It recommended that full implementation be accomplished by July 1979 and that an optimum system should involve

--a uniform accounting system and data base, 1/

coordination with health planning and capital expenditure review mechanisms,

--participation by all third-party payers, and

--mandatory participation by all hospitals.

Health Maintenance Organizations

Health Maintenance Organizations (HMOs) provide comprehensive health services--either directly or indirectly--to their enrollees and are compensated on the basis of prepaid per person rates. According to HEW, evidence has been accumulated which shows that HMOs can reduce the use of expensive services, such as hospital care, by emphasizing preventive and ambulatory services. The greater use of ambulatory services, as opposed to inpatient services, helps to contain health care costs for those enrolled in HMOs. Moreover, because the HMO has a limited number of enrollees paying a limited capitation rate, its financial solvency is not dependent on the number of illnesses it treats but rather on its ability to maintain health.

1/Public Law 95-142 requires the Secretary of HEW to establish a uniform reporting system for hospitals and other types of providers, including a uniform chart of accounts. HEW is supposed to develop this uniform system by October 1978.

During fiscal year 1978, the Ohio Medicaid progam entered into a contract with an HMO to provide medical services to Medicaid recipients on a demonstration project basis. If successful, Ohio would then use the demonstration contract model to approach other HMO providers in Ohio to provide medical services to Medicaid recipients. However, even if the demonstration project is successful, the use of HMOs does not appear to offer much immediate potential savings in Medicaid costs because Ohio had only four licensed HMOs as of June 1977. These HMOs had service areas which covered only two of Ohio's five metropolitan areas and only five nonmetropolitan counties.

Adult foster care homes

In response to evidence showing that many Medicaid patients in long-term care facilities can live in other settings, Ohio is considering various alternatives, such as establishing certified adult foster care homes. In theory, these homes would save the State money because its costs to cover foster home care would be less than its share of Medicaid payments to a long-term care facility. However, this proposal had not been initiated at the time of our fieldwork because the State believes several matters needed to be resolved first, including:

--Providing funds and staff for such tasks as writing the policies and procedures, certifying the homes, and administering the program.

--Evaluating the possibility that savings would not result because the foster care homes could house eligible recipients other than those who would have been institutionalized in medical facilities.

On November 23, 1977, a State law became effective which allowed the State Medicaid agency to establish alternatives to institutionalization projects. As of May 1, 1978, the State agency had two projects which contained adult foster care programs. Three similar projects were being developed. The State had established a $1.5 million fund for alternatives to institutionalization projects.

CONCLUSIONS

Ohio's efforts to contain Medicaid costs have involved (1) restricting benefits to promote efficiency and curb

abuses, (2) reducing temporarily benefits and payments to balance budgets, and (3) studying alternatives to existing benefit programs and reimbursement methods. If Ohio decides to implement further restrictions, reductions, or alternatives, it should be careful to avoid the pitfalls such as apparent failure to comply with State law concerning reimbursement methods encountered while implementing the temporary payment reductions during 1975.

AGENCY COMMENTS

The State Medicaid agency said that if it had to implement reductions again, it would certainly approach the task somewhat differently. It pointed out that the types of cost containment efforts undertaken were relatively new to the State and that the experience gained should prove useful in the future.

CHAPTER 4

NEED FOR IMPROVED MANAGEMENT OF THE ELIGIBILITY PROCESS

Some ineligible recipients have received Medicaid payments because they misrepresented their circumstances or agency employees made errors in determining eligibility. Despite Ohio's efforts to reduce ineligibles, it has one of the highest ineligibility rates in the Nation.

The Department of Health, Education, and Welfare requires Ohio to have Medicaid and Aid to Families with Dependent Children quality control systems to ensure the proper expenditure of public assistance funds by identifying unacceptable performance and recommending corrective actions. The HEW quality control procedures do not differentiate between technical errors and substantive errors. True program losses due to ineligibility are, thus, overstated. 1/

From April to September 1976, Ohio reported, based on its quality control sample, that about $34.4 million had been expended on services for ineligibles. We adjusted this amount by deleting technical overpayments which resulted in estimated erroneous payments of about $15.2 million. Also, because of the nature of the problems which caused ineligibility, our $15.2 million estimate probably overstates potential Medicaid savings available from eliminating ineligibles.

Although Medicaid is a State designed and supervised program, eligibility in Ohio is determined locally by 88 county welfare departments. The management of county offices directly affects errors in Medicaid and other welfare programs. Our visits to three counties disclosed several common problems including high workload, high staff turnover, inconsistent emphasis on training, lack of quality control, and poor communication with the State agency. Until Ohio takes action to minimize these problems, significant errors will continue in the Medicaid program.

1/ We previously reported (see HRD-76-164, Aug. 1, 1977) that a similar problem existed in the method for reporting savings associated with reduced AFDC ineligibles under AFDC's quality control program.

OHIO'S QUALITY CONTROL REVIEWS

Quality control, as used by public assistance agencies, is an adoption of a technique which is used widely in industry for evaluating and controlling the quality of products or services. Ohio uses a quality control system developed by HEW to help insure proper and correct expenditures of public assistance funds by identifying unacceptable performance and ineffective policies and correcting them. These objectives are accomplished by

--continually reviewing recipient eligiblity through statewide statistically reliable samples of payments and medical claims;

--periodically assembling and analyzing review findings to determine the incidence, dollar amount, and cause of eligibility and overpayment errors; and

--formulating and applying corrective actions to reduce errors.

Ohio has separate quality control systems for each of its two major public assistance programs--AFDC and Medicaid. In general, the methods employed by both programs are similar.

Effective July 1, 1975, Federal regulations mandated that States initiate quality control programs for Medicaid. Since then the Bureau of Quality Control within Ohio's Welfare Department has been responsible for sampling and analyzing Medicaid cases. HEW's Medicaid quality control system is modeled after its AFDC quality control program except that Medicaid cases were selected from paid claims instead of monthly public assistance checks. Each paid claim is for a specific unit of service provided to a single recipient. States are required to use the HEW-designed quality control systems. Ohio's quality control program involved selecting and using statistically reliable statewide samples of about 400 Medicaid and 1200 AFDC cases during each 6-month reporting period.

Our review of cases determined to be ineligible under the quality control program showed that the determinations were generally correct. Few reports of ineligibility were contested by the counties or changed by the State. County officials advised us that the thoroughness of quality control procedures insures that errors will be found, but they said county caseworkers have neither the time nor the resources which quality control uses for each of its cases.

Technical versus substantive errors in eligibility

Errors identified during the case review process are tabulated by number and cause and projected to total expenditures covered by the Medicaid quality control program. The data is consolidated in semiannual reports to HEW which show, among other things, the case error rate for ineligibles and the program dollars lost due to these errors. Such rates, however, do not accurately represent misspent public funds.

Quality control review findings indicate that the major cause of Medicaid eligibility errors is excess personal resources. In Ohio, Medicaid eligibility is restricted to those whose personal resources do not exceed

--$300 in liquid assets (cash, savings, bonds, etc.),

--$500 in face value of life insurance or a $800 burial contract, and

--$2,250 in total personal resources.

These requirements result in a high incidence of technical and temporary ineligibility which is reflected in Ohio's error rate--technical because an eligibility requirement is often exceeded only by a nominal amount, and temporary because once realized and adjusted by the recipient (by disposing of excess resources), the discrepency does not affect the actual Medicaid eligibility of the recipient.

An example of such an error is the $25-monthly personal allowance for institutionalized recipients. Recipients can keep this amount to purchase personal items such as clothes, notions, cigarettes, etc. The funds are often maintained by the institution. Frequently, the recipient does not spend this allowance and it is accumulated by the institution. Within 13 months, the recipient's personal allowance can exceed the $300 liquid assets limit for Medicaid causing technical ineligibility for further benefits. Spending the excess amount restores Medicaid eligibility.

While a mechanism does exist to assign the excess resources to the cost of care, most county welfare departments are not sufficiently staffed to monitor affected cases and to make this adjustment. Similar problems exist in interest-bearing savings accounts, life insurance policies, and burial contracts.

The Ohio Medicaid quality control report covering the April to September 1976 period estimated that 20.9 percent of institutional claims were paid on behalf of ineligibles and that erroneous payments for these claims totaled about $30.3 million. For noninstitutional claims, the estimates were 15.3 percent and $4.1 million, respectively. However, HEW's quality control reporting criteria does not differentiate between technical and substantive eligibility errors. Consequently, the computation of program error rates and and related dollar loss in the Medicaid program can be misleading because the total amount of the claim is used in computing dollar loss, instead of the amount by which resource limits are exceeded. Therefore, we decided to analyze the quality control cases to determine the extent of "technical errors". For the 76 cases found ineligible by quality control, our analysis showed that the errors were in the following categories.

Reason for ineligibility	Number of cases	Range of amounts in excess of limits	
		Low	High
Amount in checking and/or savings account(s) exceeds $300 liquid assets limit	26	$6	$5,841
Amount in personal allowance account maintained by nursing home exceeds $300 liquid assets limit	14	6	472
Life insurance with face value over $500, burial agreement valued over $800, or having both life insurance and burial agreement	7	244	4,500
Income, normally from pensions, higher than reported causing spend-down amount to be incorrect	7	9	85
Having more than $300 in cash	4	347	1,018
Owning unallowable real property	4	1,140	12,800

Reason for ineligibility	Number of cases	Range of amounts in excess of limits	
		Low	High
Ineligible because of living arrangements	1	Not applicable	Not applicable
A combination of two or more of the above	13	$22	$2,175

We considered all of these cases, except for a few with large excesses, to have elements of technical ineligibility because recipients could become eligible by spending only a small amount of funds.

We adjusted the amounts the quality control study showed to have been erroneously paid to include only the amount by which the limits were exceeded in order to estimate the amount of funds which could be saved by eliminating ineligibility. For example, quality control found one $4,200 claim to be ineligible for payment because the recipient had a savings account which exceeded the $300 limit by $18.77. The entire $4,200 payment was classified as erroneous by quality control but, since the person would have had to spend only $19 to become eligible, we considered only the $19 to be an erroneous payment.

Quality control found another case ineligible because a woman had a personal allowance account which exceeded the $300 liquid assets limit by $22.79. Quality control considered all of the $290 claim as erroneous while we considered only $23 as erroneous. Subsequent to the quality control review, the recipient bought some clothing which lowered her personal account below the ceiling and she remained eligible for Medicaid.

After making these adjustments, we recomputed the estimated amount of erroneous payments. The revised estimate was $15.2 million or 44 percent of quality control's estimate, made using HEW's formula, of $34.4 million.

Our $15.2 million estimate probably overstates possible Medicaid's savings by eliminating ineligibility because many of the ineligible individuals would not have had to apply their excesses to the cost of medical care. They could have used the excesses to purchase personal items, such as clothing or radios, and, thereby, lower their resources below the applicable limits without lowering Medicaid expenditures.

We noted that, when Ohio experienced relatively high error rates in AFDC eligibility determinations because of excess personal resources, the State increased its AFDC resource limits to lower error rates.

In order to determine if the overstating of erroneous Medicaid payments problem was more widespread than Ohio, we randomly selected five other States and looked at their Medicaid quality control reports for the same time period. These reports showed that similar overstatement problems probably existed in these States because many of their ineligible cases resulted from the same reasons. Specifically,

--57 percent of the cases were ineligible because the liquid assets limit was exceeded and

--19 percent were ineligible because insurance limits were exceeded.

HEW reported estimated losses of about $1 billion from April to September 1976 due to ineligible recipients. Based on the results of our analyses of the Medicaid quality control reports, we believe it is highly doubtful that actual losses even closely approach HEW's overall reported figures.

Families receiving AFDC must meet a variety of eligibility requirements such as age, residence, living arrangement, limited income and resources, and absence, incapacity, or unemployment of one parent. The complexity of these requirements and the size of the client population, as well as other factors, has led to a high incidence of eligibility errors in some States, including Ohio. Since AFDC recipients are automatically eligible for Medicaid benefits, ineligible recipients can unnecessarily increase Medicaid costs.

Ohio's AFDC ineligibility error rate has steadily decreased. For the April to September 1973 period, Ohio reported that 13.7 percent of all AFDC recipients were ineligible for AFDC assistance. For the January to June 1977 period, the ineligibility rate was 7.8 percent.

The HEW formula for computing case error and program loss in Ohio's AFDC program is similar to the one used for the Medicaid program. This formula does not differentiate between those errors which are substantive and lead to savings of public assistance payments when the errors are eliminated and those which do not. Consequently, reported program losses

to ineligibles may overstate potential savings from error elimination. For example, eight AFDC cases we reviewed were declared ineligible by quality control because a member of the assistance group had not registered for work as required. Following the receipt of the quality control report, the recipients registered for work and remained eligible for AFDC and Medicaid.

CORRECTIVE ACTION TO REDUCE ERRORS

Corrective action is an ongoing administrative process which uses quality control findings to develop cost-effective methods to eliminate payment errors. This process has two dimensions (1) correction of individual sample cases found in error and (2) the development and implementation of a corrective action plan designed to identify and eliminate the causes of common errors.

Individual corrective action

Correction of individual sample cases found ineligible is a by product of the quality control system. Such cases are referred to the responsible county welfare department for appropriate action, including termination. Our review of Medicaid and AFDC cases found ineligible by quality control during 1976 showed

--some ineligibles were not terminated promptly which caused unauthorized payments and

--the control system which was designed to ensure prompt county action on ineligible sample cases was not effective.

Also, because they met the eligibility requirements for personal resources subsequent to the review period by applying their excess assets to provider payments or the purchase of personal items, 48 percent of the Medicaid ineligibles identified by quality control during the April through September 1976 period were not terminated by the county welfare departments. Six percent of the AFDC cases were similarly continued in the program when work registration or other eligibility requirements which resulted in technical ineligibility were met.

Some Medicaid and AFDC cases were not promptly terminated by the counties because

--delays occurred while caseworkers ensured the accuracy of quality control findings,

--the recipient was exercising the right of appeal,

--cases became misplaced, and

--termination requests were not processed promptly.

We discussed the need to perform a full case review of cases found in error with officials of two counties. They agreed that an extensive review may not be needed because quality control findings are generally correct and each recipient may have a complete and impartial review of the termination by a State hearing officer.

The control system designed by the State to ensure prompt action on cases found in error by quality control was implemented in March 1976. The system was not functioning effectively because the quality control staff had responsibility for monitoring county activities, but the staff did not have supervisory responsibility for the corrective action taken by counties on individual cases. This resulted in delays in initiating corrective action. Also, our review showed that due to limited staff, the quality control staff was not always properly following up on Medicaid cases it found ineligible and that district offices did not always follow up on AFDC cases found in error.

Programmatic corrective action

Federal regulations require all State agencies to submit a plan to HEW which describes the major concentrations of errors, the basic causes of those errors, the corrective action taken or planned to reduce the errors, and the results realized or anticipated. Generally, Ohio's AFDC corrective actions have been tailored to those eligibility factors which quality control statistics show account for most ineligibles. However, Ohio had been slow to implement programmatic corrective action in the Medicaid program.

The State's corrective action panel reviewed the statistical data obtained from Medicaid quality control reviews and recommended that the State agency and counties take several corrective measures to reduce common errors, such as reviewing nursing home patients' personal accounts to assure they do not exceed the $300 limitation. Yet some of these

measures had not been implemented. A panel member explained that Medicaid corrective action has not been given sufficient attention because (1) the State agency's attention has been directed toward resolving the Federal compliance issues arising from the State's medical assistance plan and (2) the State has emphasized AFDC corrective actions to avoid fiscal sanctions which HEW had threatened to take prior to March 1977.

LOCAL AND STATE ADMINISTRATIVE MANAGEMENT PROBLEMS IMPACT ON MEDICAID ELIGIBILITY

Ohio's Medicaid program is designed, supervised, and partially funded by the State. Program implementation, however, is the responsibility of 88 county welfare departments, and Medicaid eligibility is related to a great extent to the manner in which these departments administer the AFDC program. We reviewed the activities of three county welfare departments to determine how local management problems have affected the State's error rates. For example:

--Quality control statistics show that case errors caused by county workers account for about 34 percent of Ohio's AFDC error rate. Despite State initiated corrective action, this percentage has remained nearly constant since July 1975.

--Applications for public assistance are not processed promptly. Although Federal regulations permit only a 45-day period for a determination of eligibility for AFDC, in April 1977, 60 percent of the State's AFDC applications in process had been pending for 61 days or more.

--Redeterminations of program eligibility are also not done in a timely manner. In March 1977, about 23,000 Medicaid and 35,000 AFDC cases were overdue for required examinations of eligibility. Some were more than 1 year delinquent.

Our review at the county welfare departments identified a number of administrative problems that affected the effective management of the Medicaid program. These problems are not new, they have been identified and reported on since the beginning of the welfare programs. They are being briefly discussed in this chapter because they affect the State's ability to control Medicaid costs.

Large caseloads

Ohio's Public Assistance Manual established standard caseloads of 475 for Medicaid and 275 for AFDC caseworkers. This standard was developed and incorporated into the State's procedures in 1974 when the declaration method of eligibility determination was in use. This method included little verification of the information provided by an applicant and permitted local workers to handle hundreds of cases per month. However, resulting error rates were unacceptably high. Beginning in 1975 the State strengthened the verification requirements for eligibility information. Because the performance standard for case workers has not changed while the work requirements have increased, applications take longer to process and redeterminations are not performed at the required interval.

Staff turnover

The turnover of caseworkers, especially in the urban county welfare departments, is a serious management problem. In one urban county, turnover among entry level income maintenance workers was about 80 percent in 1976. High turnover usually results in a low level of experience and consequent inefficiencies in ongoing case management. Redeterminations of eligibiity are often delinquent and not thoroughly performed. Vacant positions are common, which adds to the already high workload of the remaining employees. Supervisors must train new employees, assist in handling the caseloads, and review the work of subordinates. In many cases supervisors are unable to do all of these functions effectively. County officials believe high turnover exists among entry level employees because

--salaries are low,

--caseloads are high,

--entry level employees serve as a pool from which higher-level positions are filled, and

--caseworkers are dissatisfied with income maintenance tasks which emphasize administrative skills while other jobs emphasize service to recipients.

Inconsistent training programs

Initial and ongoing training programs are one means available to county welfare departments to reduce agency-caused eligibility errors. We visited two counties which did not have formal job-related training programs for new and inservice employees. One county explained that training was unnecessary since all staff members work with the director daily. Officials at the other county explained that training programs have not been implemented because of

--limited funds,

--conflicts between workload and training needs,

--uncertainty as to what training should be included in a program and what should remain the supervisor's responsibility,

--limited prior notice of State policy and procedure changes, and

--high turnover of new employees.

Officials from all the counties visited said that policy and procedure changes issued by the State are so numerous, and at times unclear, that timely training of caseworkers is difficult. Consequently, policy implementation is impeded and at times in error. These officials said that meaningful input into policy changes and implementation strategies would result in more effective case management.

Lack of county quality control

Two of the counties we visited had quality control units but they did not evaluate the accuracy of eligibility or payment decisions. For the most part these units responded to State quality control findings. County officials said that internal quality control systems had not received priority because of limited personnel and a lack of knowledge about implementing such programs. We were told that while the State has encouraged county initiated corrective action programs, little information about statistical sampling and error cause analysis had been provided.

Need for improved communication

The State has divided the 88 county welfare departments into 5 geographic districts and made the district directors responsible for liaison and supervision. District officials are supposed to provide support and technical assistance to the counties in their areas. County officials believe that this system has a number of drawbacks such as:

--Counties are too far removed organizationally from State officials to effect prompt resolution of pressing problems.

--District officials must often contact State personnel to resolve a county's question, and because of communication breakdowns, incomplete responses to inquiries sometimes result.

--Policy clarifications are often delayed; some have taken as long as 6 months to receive.

Officials in all three counties said that State directives have been received without sufficient time to implement these directives. Some directives are unclear when received and require clarification which further impedes adoption.

CONCLUSIONS

Ohio's Medicaid and AFDC quality control systems identify and report the incidence and cause of errors to HEW and recommend corrective actions. Many of Ohio's Medicaid eligibility errors are due to recipients who have personal resources in excess of the State's standard under Medicaid. County staff do not adequately monitor and assist recipients in meeting program requirements. When Ohio experienced similar problems in its AFDC program, personal resource limits were increased.

HEW's required quality control procedures for tabulating and reporting Medicaid case errors do not differentiate between substantive errors which cause program losses and technical errors due to unfulfilled procedural requirements. Medicaid program losses due to eligibility errors are thus overstated, as can be program savings attributed to error rate reductions.

Administrative management problems persist at the State and local levels of the welfare program. These problems effect the ability of the State to control the eligibility status of many AFDC recipients who are eligible also for Medicaid. We believe corrective actions on these problems are necessary to help the State to control Medicaid costs.

RECOMMENDATIONS

We recommend that Ohio:

--Assess the usefulness of its Medicaid eligibility requirements for allowable personal resources. If these are retained, stronger management procedures should be developed and implemented to reduce the substantial number of eligibility errors attributed to these requirements.

--Strengthen the control procedures developed to ensure counties promptly correct Medicaid and AFDC cases found in error by quality control. Also, additional management attention should be applied to the development and implementation of corrective actions in the State's Medicaid program.

--Examine the administration of Medicaid and other welfare programs by county welfare departments. As a first step in this process, existing communication channels should be improved and a cost benefit analysis of increasing administrative resources in urban counties should be conducted. The State should also consider establishing internal quality control systems in urban counties modeled after the State system.

AGENCY COMMENTS

The State Medicaid agency agreed with our recommendations and stated it intended to seek increased funding for administrative resources in the 1979-80 biennial budget to implement our recommendations. The State agency also said the system to ensure prompt county action on quality control findings has been strengthened by a reorganization of related functions and by increased staffing.

The State agency strongly agreed with our findings and conclusions regarding HEW's required method of reporting Medicaid quality control results and has communicated this to HEW.

CHAPTER 5

MEDICAID SAVINGS THROUGH IMPROVEMENT OF PROGRAMS IMPACTING ON ELIGIBILITY

Inadequate management controls over several programs have influenced the number of Medicaid eligibles in Ohio and have resulted in unnecessary expenditures. The State agency has not devoted sufficient effort to analyzing these problems.

Medicaid's program to ensure that Medicare pays first for services provided to recipients eligible for both programs is not functioning as effectively as it could. As a result, administrative workload is higher than necessary and some eligible recipients are not promptly enrolled in Medicare which increases administrative expenses.

The State was spending an estimated $230,000 a month to provide medical services to ineligible persons who are employed and receive earnings in excess of the State's standard. Although 4 additional months of Medicaid coverage are provided by law after an Aid to Families with Dependent Children family loses cash assistance due to increased earnings, many such families in Ohio received more than the additional 4 months coverage. Improvements in the State's computer system and revisions to county operating procedures were needed.

The State agency did not hear appeals of public assistance and Medicaid issues within federally prescribed time limits. Delays in the hearing process can be costly as benefits must continue until a hearing decision is rendered. A U.S. district court ordered Ohio to comply with Federal regulations regarding timely hearings by August 1, 1977.

MEDICAID SAVINGS ARE AVAILABLE THROUGH THE MEDICARE BUY-IN PROGRAM

The Social Security Act provided States the opportunity to enter into an agreement with the Department of Health, Education, and Welfare for participation in the Medicare "buy-in" program. Under this program, the State pays the monthly insurance premiums, coinsurance, and deductibles using Medicaid funds for Medicaid recipients who are also

eligible for Medicare part B Supplemental Medical Insurance. The buy-in program allows the State to transfer some of the medical expenses of Medicaid recipients to the 100-percent federally funded Medicare health insurance program.

Ohio has a buy-in agreement with HEW whereby it enrolls all Medicaid recipients in Medicare part B if the recipients are

--over 65 years of age,

--Medicare part A beneficiaries, or

--disabled persons who have received Social Security disability benefits for 24 months.

Because Ohio makes its own Medicaid eligibility determinations, the State agency is responsible for identifying and enrolling eligible persons in the buy-in program and deleting ineligibles. The State identifies buy-in eligibles through two information sources--the Social Security Administration and county welfare departments. In July 1977, over 82,000 of Ohio's aged, blind, and disabled Medicaid recipients were enrolled in the buy-in program.

Although virtually all aged Medicaid recipients are eligible for Medicare part B participation, about 5,400 who the State agency had identified were pending buy-ins. Similarly, the State agency had identified about 6,000 disabled persons as eligible for Medicare part B whom the State was attempting to buy in. Although all Medicaid recipients who also become eligible for Medicare are bought in retroactively to the earliest date of dual eligibility once they are enrolled, delays in the buy-in process cause increased administrative workloads at the Federal, State, and county levels.

In addition, our examination of Medicaid case files showed that some disabled recipients who were eligible for buy-ins had not been identified by the State agency. To determine why these recipients were not enrolled in the Medicare part B program, we reviewed 332 randomly selected Medicaid cases in three counties. We also discussed management problems in the buy-in program with State and county officials. Reasons for eligibles not being identified and promptly enrolled in part B of Medicare included:

--Aged persons did not apply for Medicare at local SSA offices, and county welfare departments did not promptly apply for them.

--Data supplied by Ohio did not match SSA records; therefore, SSA did not accept most of its buy-ins.

--Some disabled eligibles were not being identified by the county welfare departments.

Aged persons must apply for Medicare part A benefits at their local SSA office and obtain a health insurance claim number before the State agency can enroll them in the buy-in program under part B. County caseworkers are supposed to identify, with State agency assistance, and encourage eligible aged persons to apply for Medicare. If these recipients are unwilling, or do not apply, the counties should apply for them.

County officials advised us that some aged persons do not apply for Medicare because of (1) confusion about the differences between Medicaid and Medicare and (2) the absence of public transportation. The State agency had not established a time limit to guide the counties on when they should apply on behalf of an eligible recipient for Medicare, and caseworkers were reluctant to use discretion in this matter.

Because the State agency attempts to buy-in all aged Medicaid recipients, whether or not a health insurance number has been obtained, SSA rejects many of the buy-ins. These rejections add to the State agency's and SSA's administrative burden because they must be resolved and resubmitted.

In order to promptly buy-in into Medicare, the State must have accurate and timely information from the county welfare departments and an efficient, automated system for processing the information and communicating with SSA. Our review of county and State buy-in operations indicated that these processes were not functioning effectively. During January through July 1977, the State submitted 47,487 buy-in requests to SSA and only 12,230 were accepted. The remainder were rejected because they did not match SSA records.

State officials explained that the data submitted must match SSA records exactly or a buy-in will not be accepted. For example, a misplaced letter in a recipient's name or

one inaccurate digit in a date of birth or health insurance claim number will result in a buy-in being rejected. State officials believed county caseworkers did not understand how the buy-in program works and fail to follow the State's instructions. Because SSA's listing of Social Security beneficiaries and Medicare part B eligibles provided to the State is not always current, the State agency relied on information submitted by the counties.

County officials said that:

--Accurate information was often difficult to obtain from Medicaid recipients. Until recently, dates of birth were particularly troublesome for some aged recipients because records of their birth did not exist or could not be found.

--The State buy-in instructions were inadequate because they did not explain how the program works and were not consolidated in one manual.

--The State often sent inaccurate SSA beneficiary information to the counties.

County officials said that these factors, coupled with heavy caseloads, resulted in some recipients eligible for buy-ins not being identified.

At the State level, most buy-in procedures are automated. Each month the State's computer automatically attempts to buy-in Medicaid cases that have health insurance claim numbers or dates of birth indicating that the recipients are 65 years old or older. This system results in unsuccessful buy-in attempts because

--it does not ensure disabled recipients have received SSA benefits for 24 months which is required for Medicare eligibility and

--it will attempt to buy-in an aged person even though he/she has no health insurance claim number.

The State computer automatically prints a notice when SSA rejects a buy-in. If the reasons for rejection cannot be found by State personnel, a research notice is forwarded to the responsible county welfare department for resolution. County caseworkers must then review their case files and

resubmit correct data. County officials said that the notices do not indicate which piece of information did not match SSA's data. In many cases, the same data is forwarded to the State because the counties cannot identify any incorrect data. When the county receives a second notice on the same case, a local inquiry to SSA is generally made. Several months can be lost while such problems are resolved, and as noted above, about 75 percent of buy-ins are rejected the first time they are submitted to SSA.

SSA provides the State a Beneficiary Data Exchange report which lists Medicaid recipients who are receiving benefits under title II of the Social Security Act (Old Age, Survivors, and Disability Insurance), and although this data is 3 or more months old, it should be useful to the State in enrolling Medicaid recipients. If the information the State has on the recipient does not match the data on this SSA report, it is a good indication that a buy-in attempt will be rejected. The State could use the SSA report to validate data on buy-in requests for recipients on the report and could ensure that requirements, such as application for Medicare, have been met by those not listed. This would help eliminate many of the administrative problems now occuring in the buy-in program.

SSA also provides the States with a report called the State Data Exchange report which contains Medicare eligibility information for all SSI recipients residing in the State. This report could also be used to validate data on buy-in requests before they are submitted.

Of the 227 disabled Medicaid cases reviewed in one Ohio county, we found 4 recipients who were receiving SSA disability benefits and eligible for the buy-in program, but who had not been identified by the State agency. We also found 2 of 105 eligibles who had not been enrolled in the buy-in program in the two other counties. If this situation is typical of all counties in the State, Ohio could be missing as many as 2,000 Medicaid recipients eligible for Medicare part B.

The State could later be retroactively reimbursed by Medicare for these eligibles' covered medical costs if and when they are identified and bought-in. However, at least in the short run, Ohio is unnecessarily expending Medicaid funds.

MEDICAID BENEFITS OF THOSE EMPLOYED SHOULD BE TERMINATED AFTER 4 MONTHS

The 1972 amendments to the Social Security Act extended the Medicaid coverage of AFDC families who became ineligible for cash assistance due to increased earnings. Thus, even though a family becomes ineligible for continued cash assistance, Medicaid benefits can continue fo. an additional 4 months.

Previous audit work by us 1/, the Ohio State Auditor's office, and this review have identified problems in the State's handling of 4-month Medicaid extension cases. These problems have resulted in Medicaid benefits being provided to persons whose eligibility has expired. In 1975, the State Auditor's office identified many Medicaid extension cases that were incorrectly coded and, as a result, were not terminated after 4 months. The State Auditor recommended that the State program its computer to automatically terminate Medicaid extension cases if no changes were reported in case status at the end of the fourth month. This recommendation, however, was not implemented.

Ohio's Public Assistance Manual contains guidelines for authorizing the 4-month Medicaid extensions to AFDC families. To be eligible for the extension, an AFDC family must have received cash assistance in at least 3 of the last 6 months before becoming ineligible for cash assistance and must have lost cash assistance because of increased earnings.

In March 1977, Ohio had 4,356 AFDC cases which received medical assistance only. We selected 300 cases and found that 36 percent had been erroneously receiving Medicaid benefits for more than the allowed 4 months. Using the average monthly expenditure for these recipients in the Medicaid program, the State could have been improperly spending as much as $230,000 a month on medical services for these ineligible recipients. In many cases this situation relates

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1/Report to the Chairman, Subcommittee on Oversight, Committee on Ways and Means, U.S. House of Representatives (HRD-77-107, June 7, 1977).

to another class of Medicaid eligibles--persons who remain eligible for AFDC and, therefore, Medicaid only as long as they can show that their work-related expenses are sufficient to lower their incomes below the AFDC income eligibility level. Problems result because the coding for these persons is very similar to the coding for 4-month extension cases.

We were told that the primary causes for extending Medicaid eligibility beyond the allowable 4-month period are:

--Sometimes cases that are to be terminated after 4 months are coded as cases with work-expense circumstances because of unclear State guidelines to county welfare workers.

--County welfare departments sometimes rely solely on individual caseworkers to take timely action on these terminations.

--The State's computer system is unable to differentiate between persons eligible for benefits because of work-related expenses and those to be terminated after 4 months. Consequently, the State has no effective control over timely terminations.

We also spoke to State and county officials about why some recipients receive 4 additional months of Medicaid after losing AFDC for reasons other than those for which a 4-month extension is allowed. The officials said that the State's guidelines are unclear and are not well understood by caseworkers. A State policy instruction issued in January 1977 to clarify procedures for Medicaid extensions was expected to be helpful in determining when and for what period Medicaid extensions should be authorized. The revision, however, does not address uniform procedures for monitoring of Medicaid extension cases to ensure timely termination.

We discussed these problems with State officials who acknowledged that the guidelines in the Public Assistance Manual were unclear and did not provide uniform procedures for the county welfare departments.

In commenting on our report, the State agency said that as we proposed, it has instituted an automatic termination procedure for 4 month Medicaid extension cases. This action should save $2.75 million a year.

The county welfare departments we visited indicated they would give increased attention to these cases and would provide some internal training to their caseworkers.

DELAYS IN PROVIDING HEARINGS TO RECIPIENTS RESULTED IN UNNECESSARY MEDICAID PAYMENTS

Ohio did not provide prompt hearings to all welfare applicants and recipients who requested them as required by Federal regulations. As a result, welfare recipients remained eligible longer than they should have. Although the State did not compute the cost of continuing Medicaid for these recipients, the cost of continuing cash assistance for the first 6 months of 1977 was over $561,000.

Federal regulations require that hearings on AFDC and Medicaid issues be decided within 90 days from the date of the hearing request. However, in Ohio these proceedings were often delayed 4 or 5 months. Since 1972 HEW periodically notified the State agency of its noncompliance with the requirement for timely hearings. A U.S. district court ordered the State to comply with these regulations by August 1, 1977.

Factors delaying the hearings process were:

--A disparity between the number of hearing requests and the number of hearing officers.

--The necessity to reschedule hearings because legal aid attorneys cannot meet the original hearing date.

--Allegedly unnecessary hearings which occur when recipients ask for hearings simply because they realize hearing officers are several months behind and their benefits will continue until their cases are heard. During the first 6 months of calendar year 1977, 32 percent of all appeals were abandoned by recipients.

--Delays in obtaining clarification of policy from the State agency.

--Administrative problems, such as failure of county welfare departments to process hearing requests promptly and limited monitoring of pending decisions for timely completion by hearing supervisors.

--The absence of a direct liaison official at HEW to resolve hearing questions and problems.

The State agency was trying to develop an automated scheduling system. When implemented this system should allow officers to more efficiently use their time by coordinating their travel itinerary with the volume of hearing requests in assigned counties.

During 1976 and 1977, Ohio attempted to bring the hearing process into compliance with Federal regulations by

--establishing a performance standard for hearing officers of 36 decisions per month exclusive of dismissed appeals,

--employing 20 law students during the summer of 1976, as hearing officers, to reduce the appeal backlog,

--adding eight new hearing officer positions,

--improving procedures for obtaining policy clarification from the State agency, and

--authorizing overtime for two of the three field hearing offices beginning in mid-July 1977.

State agency officials believe these actions have enabled them to make significant progress toward compliance with Federal regulations and with the U.S. district court order. The monthly percentage of decisions relating to cases pending over 90 days declined from 45 percent in January 1977 to 28 percent in June 1977.

Because the State was incurring about $1 million per year in cash assistance payments because of hearing delays, plus the related cost to the Medicaid program, Ohio needed to improve further the hearing process to provide more timely hearings.

MEDICAID COVERAGE OF GENERAL RELIEF RECIPIENTS MAY REDUCE OHIO'S MEDICAL ASSISTANCE COSTS

In Ohio, aged, blind, and disabled individuals who apply for Medicaid must first apply to SSA for Supplemental Security Income benefits and be declared eligible, which

can take 6 months. In the meantime, the State provides cash assistance and medical benefits, similar to those under Medicaid, to these individuals.

Except for inpatient hospital bills, the county welfare departments pay covered medical expenses of general relief recipients pending SSI determination. The counties have arrangements with the local hospitals to hold these recipients inpatient hospital bills until their Medicaid eligibility is established. If Medicaid eligibility is denied, the hospital is paid by the county, but if an individual is eligible for Medicaid then the hospital is notified to submit the claim to the State agency for reimbursement.

We believe the State and counties have an opportunity to obtain additional Federal financial participation for medical expenditures for general relief recipients who are subsequently found eligible for Medicaid. At one of the urban counties we visited, about $157,000 a year was potentially reimbursable. Considering Ohio's Federal Medicaid sharing percentage, this could save about $84,000 in State and county funds. Officials from the other two counties said that similar savings could be expected.

According to HEW officials, the State is not prohibited by regulations from claiming Federal sharing for those paid medical expenses of general relief recipients subsequently found eligible for Medicaid. A State agency official advised us that although Ohio had not considered Federal financial participation for medical payments made from general relief funds, the State was planning to explore the possibilities.

CONCLUSIONS

Overall, Ohio's buy-in program could be managed more effectively. Although most Medicaid recipients eligible for Medicare part B are identified and enrolled by the State, a significant number are not enrolled promptly. Such delays increase administrative workload. Some disabled Medicare part B eligibles are not promptly identified by the State which causes, at leasc temporarily, unnecessary Medicaid expenditures for medical services covered by Medicare.

The State implemented our proposal to devise an automatic procedure to terminate Medicaid recipients who lose eligibility because of increased income at the end of their 4-month eligibility period. This should result in Medicaid savings of about $2.75 million a year.

The State was not claiming Federal sharing in the costs of paying for medical care out of its general relief funds for individuals waiting for a determination of Medicaid eligibility. If those people are later found eligible for Medicaid, it is possible to claim Federal sharing for these costs and the State and counties could reduce their costs of providing medical services to the poor.

Delays in providing hearings to Medicaid recipients have resulted in unnecessary Medicaid payments. The State needed to take action to assure that such delays are minimized.

RECOMMENDATIONS

We recommend that Ohio improve the buy-in program by:

--Developing a buy-in handbook for the county welfare departments consolidating and clarifying buy-in procedures.

--Requiring county caseworkers to obtain full social security information for each Medicaid applicant and regularly update this information on each case.

--Establishing a time limit for the counties to submit a Medicare application for aged recipients who have failed to enroll on their own.

--Working with SSA to obtain more current and complete data on Medicare part B eligibility.

--Attempting to enroll only those cases which match SSA Medicare eligibility files to avoid the numerous rejects presently occuring which slow down the entire buy-in process.

We also recommend the following measures to improve control of Medicaid extensions for terminated AFDC recipients:

--Initiate a desk review of all AFDC cases coded as medical assistance only to ensure the Medicaid benefits provided are authorized.

--Review and revise as necessary the Ohio Public Assistance Manual to clarify the procedures for authorization, monitoring, and terminating 4-month Medicaid only cases.

To provide for prompt State hearings to Medicaid and other public assistance recipients, we recommend the preparation of an analysis of the hearings program which includes

--an assessment of the current and expected future hearings workload to determine staffing needs required to meet Federal regulations and

--the reasons appeals are made by recipients to determine if actions by the counties can eliminate them and reduce the volume of hearings.

Furthermore, we recommend action to obtain Federal financial participation for paid medical expenses of general relief recipients subsequently found eligible for Medicaid.

AGENCY COMMENTS

The State Medicaid agency agreed with our recommendations. The State agency said that it

--would develop a buy-in handbook for the county welfare departments and that the counties are now obtaining and regularly updating full Social Security identifying information for each Medicaid applicant and recipient,

--would require counties to submit Medicare applications for Medicaid recipients who fail to do so themselves within 30 days,

--has requested funds to staff an administrative unit which would be available to assist in the hearings process during periods of peak volume and, thereby, hold down hearings backlogs,

--is working on a system which will compile hearings data and identify for county welfare departments corrective actions that could reduce the volume of appeals necessitating hearings,

--has implemented a coding system which provides the capability to identify hearing requests by the month of the request and, thereby, allows monitoring of the timeliness of the disposition of hearing requests, and

--would establish procedures to identify medical payments for general relief recipients subsequently found eligible for Medicaid and claim Federal sharing in such payments.

The State agency said that although it agreed with our recommendation that the State only attempt to buy-in cases which match Medicare eligibility files, it did not understand how it could do so because it believed there was no way of knowing if cases would match before being submitted to SSA. As discussed on page 38, SSA provides the State with two reports--the Beneficiary Data Exchange and the State Data Exchange reports--which can provide information on the Medicare eligibility of SSI and other recipients. By comparing State information with that on the SSA reports, the State can determine which cases will most likely result in buy-in rejections and correct the errors before submitting a buy-in request.

The State agency said that, as of the last reporting cycle, 92 percent of all hearings were decided within the 90-day limit. The State agency also said that on April 14, 1978, HEW notified the State that it was in compliance with the 90-day requirement. The State believes it now has the hearings problem under control. This should result in substantial savings of both cash assistance and Medicaid funds.

CHAPTER 6

IMPROVEMENTS NEEDED IN SETTING PAYMENT RATES

Under the Medicaid program, each State has the authority and responsibility to establish the amounts that will be paid to providers of Medicaid services. However, Federal regulations restrict the State from paying more for Medicaid services than the Federal Medicare program pays for the same services and require that payments for Medicaid services be sufficient to enlist participation from enough providers so that eligible persons can receive covered medical care and services as the general population does. Under Ohio's Medicaid program:

--Excessive payments have been made because of an inappropriate payment-setting formula for long-term care facilities and a lack of controls to assure that payments to physicians and other practitioners do not exceed legal limits.

--Fee schedules were used which made it difficult for the State to determine the availability of some services to recipients.

REVISED FORMULA ADOPTED TO PREVENT EXCESSIVE PAYMENTS TO LONG-TERM CARE FACILITIES

Federal law provides that long-term care facilities should be paid on a reasonable cost-related basis, effective July 1, 1976. Also, Federal regulations implementing this law, which were effective January 1, 1978, generally limit profit to a return on owners' equity in the facility. Because Ohio had not been following these Federal principles, we estimate Ohio had been spending an additional $23 million annually. The Ohio Legislature amended the long-term care facility reimbursement law, effective for payments after November 1977, to eliminate these excessive payments.

Reimbursement for property and equipment should be cost related

Ohio paid long-term facilities a fixed amount for each Medicaid patient day in lieu of reimbursing the facilities

for actual costs for interest, depreciation, real estate taxes, and/or rent. Specifically, facilities constructed

--before 1958 were paid $2.50 per-patient-day;

--after 1957, but before 1968, were paid, on a per-patient-day-basis (1) $3.50 if the cost of construction was more than $3,500 per bed and (2) $2.50 if the cost of construction was less than $3,500 per bed; and

--after 1967 were paid, on a per-patient-day-basis (1) $4.50 if the cost of construction was at least $5,150 per bed, (2) $3.50 if the cost of construction was less than $5,150 per bed but more than $3,500 per bed, and (3) $2.50 if the cost of construction was less than $3,500 per bed.

The Ohio State Legislature established these fixed amounts, effective July 1975. In our opinion, this practice is contrary to Public Law 92-603 and Federal regulations which require that long-term care facilities be paid on a reasonable cost-related basis. Although fixed amounts, in lieu of certain costs, are not improper per se, they should be reasonably related to actual costs.

The nursing facility industry contends that reimbursements for only depreciation and interest do not provide the cash required to satisfy mortgage and other loan payments. For example, they claim that payments for depreciation

--based on a 40-year life for a facility does not satisfy the cash requirement of a 15- to 20-year mortgage and

--based on the remaining life of the facility for life safety code improvements (sprinkler systems, etc.) does not satisfy the cash requirement for amortizing a 5- to 7-year loan.

The fixed amounts used by Ohio resulted in long-term care facilities being paid excessively for property and equipment. We estimate, based on a sample of 53 nursing homes, an average excessive payment of $1.42 per-patient-day. We projected this to the 11.6 million patient days paid by Medicaid which resulted in estimated excessive

payments of about $16.5 million annually. Other studies have also suggested that excessive payments were being made. For example:

--The State agency prepared a 1977 study and analyzed data from 300 facilities and found that in 1976 the fixed amounts averaged $1.29 per-patient-day in excess of actual costs.

--A public accounting firm made a study for an association of nursing home owners and analyzed 1976 data from 95 facilities and found that the fixed amount averaged $3.55 per patient day--$1.49 more than the actual cost of $2.06.

Profit allowance should be based on net equity

In addition to the property and equipment allowance, the State legislature established (effective July 1975) a profit allowance for proprietary long-term care facilities equal to 10 percent of the cost incurred (not to exceed $1.50 per-patient-day) for the care, comfort, and safety of Medicaid patients. This profit allowance is in conflict with Federal regulations which prohibit using a "cost-plus-a-percentage-of-cost" method to pay providers. Before July 1975 the profit allowance was based on the owners' net equity.

It appears that the legislature opted for the percentage of cost method because of the nursing home industry's contention that using the net equity method causes many facilities to receive little or no profit to invest in capital expansion, since they often have a small or even negative net equity.

Based on our sample of 53 nursing homes, where we found an excess payment of $0.66 per-patient-day, we estimated that Ohio could have saved about $6.5 million annually if profits were computed on net equity instead of operating cost ($0.66 per patient day x 9.9 million Medicaid patient days in proprietary facilities).

Ohio revises State law to comply with Federal requirements

In September 1976 the HEW regional office notified the Ohio Medicaid program that its method of reimbursing long-term care facilities was counter to Federal requirements. On November 12, 1976, the State sent a letter to long-term care facilities notifying them that effective January 1, 1977

--reimbursement for property, equipment, and/or rent would be based on their actual costs and

--profit allowance would be computed as a percentage of the owners' net equity capital, not to exceed $1.50 per patient per day.

A December 8, 1976, State court of appeals order prevented these changes from being implemented. The court acted on the nursing home operators' complaint that under State law the Ohio Medicaid program could not implement these changes without approval of the State controlling board--a panel of six members of the legislature and one member from the executive branch. On January 24, 1977, the controlling board rejected the Ohio Medicaid program's request to approve these changes, apparently to give the long-term care facility industry time to challenge the proposed changes in court.

As requested by the Ohio Medicaid program, the State legislature in August 1977 revised the State law, effective December 1977, to provide that reimbursement for property, equipment, and/or rent be based on the facilities' book cost with reimbursements limited to ceiling amounts and that profit allowance be computed as a percentage of the owners' equity capital, not to exceed $1.50 per patient per day.

CONTROLS NEEDED TO PREVENT OVERPAYMENTS TO PRACTITIONERS

Federal regulations restrict Federal sharing in Medicaid payments to individual practitioners (doctors of medicine, dentristy, osteopathy, podiatry, etc.) to the lowest of their

--actual charge for the service,

--reasonable charge recognized under part B of Medicare, or

--usual and customary charges.

Ohio had no controls to assure that payments did not exceed the latter two limits. Data necessary to make these comparisons was not obtained or accumulated. The claims-processing system only compared the practitioner's actual charge to the State's fee schedule.

As a result, over the years Ohio has paid practitioners more than Federal upper limits allow. We did not determine the amount of the excessive payments; however, it appears that millions of dollars were misspent. For example, our sample of 50 out of more than 16,000 individual practitioners showed overpayments of about $100,000 for just two procedures--routine office visits and hospital visits.

Payments made in excess of upper limits set by Medicare

The reasonable charge under part B of Medicare is the lower of the individual practitioner's actual charge, usual and customary charges, or the prevailing charge in a given locality. Ohio has no data on the usual and customary charges of individual practitioners in Ohio. The State used Medicare prevailing charges for all practitioners, except dentists, when it established its current Medicaid fee schedule in 1969. Since then, however, considerable overpayments have occurred because Ohio did not reduce fees when Medicare prevailing charges were lowered in January 1970 due to an HEW change in procedures used to compute prevailing charges.

As would be expected, overpayments were large just after the Medicare rollback and gradually decreased as the Medicare prevailing charges increased over the years, as illustrated in the following table.

Maximum Medicaid Fees and Medicare Prevailing Charges for Selected Services for General Practitioners in the Cleveland Area

	Ohio's maximum Medicaid fee	Medicare part B prevailing charges		
		Effective May 1969	Effective January 1970	Effective Oct. 1976 (note a)
Complete history and physical, office visit	$25.00	$25.00	$20.00	$40.00
Routine follow up office visit	10.00	10.00	7.00	8.00
Complete histtory and physical, hospital visit	25.00	25.00	15.00	29.50
Routine follow up hospital visit	10.00	11.00	7.00	10.00

a/The Medicare prevailing charges were revised several times between January 1970 and October 1976.

By October 1976, most, but not all, Medicare prevailing charges equalled or exceeded the Medicaid fee schedule amounts. Some examples of services for which Medicaid still paid more than the part B Medicare prevailing charges for many localities are shown in the following table.

Comparison of Maximum Medicaid Fees and Medicare Prevailing Charges Effective in October 1976 for Selected Localities in Ohio

	Maximum Medicaid fee	Cincinnati	Mansfield	Lima	Springfield
Routine follow-up office visit (general practitioner)	$10.00	$ 8.90	$ 7.70	$ 7.70	$ 7.70
Chest X-ray (radiologist)	15.00	15.00	6.00	9.60	7.70
EKG (general practitioner)	20.00	16.00	15.00	19.10	19.10

Although we did not compute the amount by which Medicaid payments have exceeded Medicare prevailing charges since the Medicare rollback in 1970, it appears to be substantial. As shown in the table below, 50 general practitioners in the Cleveland area were paid about $100,000 in excess of Medicare prevailing charge limits for routine office and hospital visits for Medicaid recipients from August 1972 through December 1976.

	Visits involving excess payments			
	Number	Total payments	Upper limit per Medicare	Overpayments
Routine office	51,355	$513,131	$416,681	$96,450
Routine hospital	2,158	21,311	17,897	3,414
Total	53,513	$534,442	$434,578	$99,864

This $100,000 overpayment probably represents only a small part of the total payments which exceeded Medicare prevailing charges because the

--sample included only 50 practitioners,

--sample considered just two medical procedures, and

--largest overpayments probably occurred in 1970 and 1971; a period not included in our computation because the data was not available.

Payments made in excess of usual and customary charges

Additional overpayments occur because the usual and customary charges for many practitioners are below the Medicare prevailing charges. In these cases, the gap between the Medicaid payment and Medicare's usual and customary charges is greater than the one between the Medicaid payment and the Medicare prevailing charges. Because the Ohio Medicaid program does not compute practitioners' usual and customary charges, we used Medicare's usual and customary charges to illustrate how these overpayments occur. As shown in the following table, 3 of the 50 general practitioners in our sample were normally paid more by Medicaid for routine office visits during fiscal year 1977 than their Medicare-computed usual and customary charges 1/ which were below the $8.90 prevailing charge.

Physician	Amount paid by Medicaid	Overpayment based on Medicare prevailing charge	Medicare's customary charge for the physician	Overpayment based on Medicare customary charge
1	$10	$1.10	$8.00	$2.00
2	8	---	7.00	1.00
3	10	1.10	6.00	4.00

Medicare data could be used to prevent overpayments

Ohio could bring its claims-processing system into partial compliance with Federal requirements on payments by establishing a procedure to compare a practitioner's actual charges with his/her usual and customary charges and the Ohio fee schedule. However, Ohio must obtain and use Medicare reasonable charge data in processing claims to achieve full compliance.

1/ Medicare's usual and customary charges for July 1977 would be based on data accumulated during calendar year 1975.

Although not specifically required by HEW, Ohio should consider using Medicare prevailing charge data to revise its fee schedule. Using this data would automatically prevent Ohio from making payments which exceed Medicare's upper limits and it could eliminate another shortcoming--setting fees without considering differences in physicians practices. Specifically, the Ohio fee schedule does not consider (1) cost differences among localities and (2) recognized differences in fees among medical specialities. Medicaid law and regulations do not require that these differences be considered; however, the federally managed Medicare program, which many States use as a model in designing their Medicaid program, addresses these two areas and Federal sharing in Medicaid reimbursements is limited to the level of Medicare reimbursements.

Medicare is supposed to determine reasonable charges in a way that is equitable to providers, as well as those paying the Medicare premiums. One criterion in the Medicare law which must be considered in determining the reasonableness of the charge for a service is the prevailing charges in the locality for similar services. To meet this criterion, Medicare established individual prevailing charge limits based on physicians' charges for about 30 specialities within 15 localities in Ohio.

In addition to not recognizing locality and speciality differences, the Ohio Medicaid program fee schedule may not accurately reflect fee differences among services which Medicare recognizes. For example, the Medicaid fee schedule amounts for 15 selected surgeries ranged from 56 to 100 percent of the Medicare prevailing charges set for the Cleveland area for July 1975 through September 1976. A similar comparison of 11 services by general practitioners resulted in a range from 48 to 121 percent.

Ohio Medicaid program officials agree that Medicare reasonable charge data can be used to bring the claims-processing system into compliance with Federal requirements. However, they believe that this revision would be difficult and expensive because the Medicaid and Medicare programs are not uniform in

--the codes used to identify providers and medical procedures,

--covered benefits and limitations, and

--payment policies and procedures.

Further, they believe that maintaining the revised system would significantly increase the requirements and costs for personnel and data processing support.

UNIFORM UPDATING OF MEDICAID FEE SCHEDULES NEEDED TO CONTAIN COSTS AND ENLIST PROVIDER PARTICIPATION

Except for hospitals and long-term care facilities, Ohio pays other providers (physicians, home health care, medical supplies and equipment, prescription drugs, etc.) based on billed charges up to the maximum amount shown on its fee schedules. Ohio's HEW-approved State Medicaid plan and its Medicaid handbook distributed to providers contains criteria on the fee schedules for practitioners and prescription drugs. These documents show that the fee schedule for

--practitioners is the amount charged for the same service by 75 percent of practitioners who participate in the State Medicaid program and

--prescription drugs is the estimated acquisition cost of drugs, plus a dispensing fee, or the cost of the least expensive bioequivalent generic drug, plus a dispensing fee.

According to the handbook, the fee schedule amounts may be reduced as necessary to maintain a balanced State budget.

Ohio does not regularly update its fee schedule amounts to reflect inflation, except for prescription drugs, because it claims it lacks the funds to pay the resulting increases. However, in some years the State had funds to increase the fee schedule for some benefits, but not others. The following table shows the year of the most recent change to the fee schedules.

Year Fee Schedule Amounts Were Established for Selected Benefits (as of June 1977)

Dentists services	1966
Practitioners services (except dental)	a/1969
Medical supplies and equipment	1972
Home health care	1974
Prescribed drugs	1977

a/Minor changes to this fee schedule were made in 1971 and 1973.

In addition, Ohio does not follow its stated policy of setting the fee schedule amounts for practitioners' services on the basis of the amounts charged for the same service by 75 percent of all providers. Instead, the fee schedule amounts for

--dental services were negotiated with the State dental association which said they were set at the 60th percentile on the basis of a survey of 1966 charges to the general public and

--other practitioners were based on prevailing charge data accumulated during 1968 by Medicare in Ohio which were based on a formula designed to produce prevailing charges at the 83rd percentile of all providers' customary charges.

Services to recipients may be restricted

Ohio's failure to regularly update its fee scheduling amounts has resulted in (1) some providers being paid a higher percentage of their charges than others and (2) litigation by some providers alleging unequal treatment. The most significant effect, however, may be on recipients of Medicaid services. For example, Medicaid program officials believed that at the time of our fieldwork the fee schedule amounts for dental services and medical supplies and equipment were so low that the State might not be meeting the Federal requirement of enlisting participation from a sufficient number of providers in the program so that eligible

persons can receive covered medical care and services to the extent they are available to the general population. This contention is supported by

--statistics (see p. 6) which show that payments for dental services are relatively more concentrated in a small number of providers than other types of practitioners' services and

--evidence that the Ohio Medicaid program has increased the fee schedule amounts for a few medical supplies after all providers refused to sell the products without an increase.

Program officials would probably not be facing these problems if the State did not use the fee schedule updating function as a cost-containment measure. Ohio should balance its budgets by making across-the-board cuts in fee schedules uniformly established. It would then avoid its current practice of treating one provider group, such as physicians, more favorably than another.

In addition to the advantages discussed on page 54, Ohio's use of Medicare prevailing charge data to revise its existing fee schedule would alleviate its fee schedule maintenance deficiencies. Specifically, Medicare data is regularly and consistently updated and the use of this data would not lessen the State's ability to control Medicaid costs because Ohio could pay less than the Medicare amounts, for example 70 percent or 80 percent. Some States do exactly this.

CONCLUSIONS

Ohio's formula for setting payment rates for property costs and profits to long-term care facilities resulted in excessive payments. However, the revised formula, implemented in December 1977, eliminated these overpayments and should save about $23 million annually. In addition, Ohio's methods for setting payment rates resulted in some practitioners being paid in excess of Federal upper limits and uncertain availability of some services to recipients. As a result of using these methods, Ohio reimbursed some practitioners, such as physicians, using rates that often exceeded Federal upper limits and, at the same time, reimbursed other practitioners, such as dentists, at rates so low that their services may not be adequately available to recipients.

Ohio could obtain and use Medicare reasonable charge data to prevent payments to practitioners in excess of the upper limits available for Federal sharing which would also improve the maintenance of its fee schedules.

RECOMMENDATIONS

We recommend that Ohio take action to minimize (1) excessive Medicaid payments by establishing controls to prevent payments to practitioners that exceed the upper limits set by Federal law and (2) the possible undesirable effects on both Medicaid recipients and providers by improving its practices to set fee schedules.

AGENCY COMMENTS

The State Medicaid agency said it was making a complete review of upper limits on fees. The State will use Medicare prevailing charge data to assure that it complies with Federal requirements for upper limits on Medicaid practitioner payments.

The State agency said it also has

--comprehensively revised its medical supply formulary and adjusted upper limits on payments,

--increased dental service allowable fee limits, and

--increased the pharmacy dispensing fee.

In addition, the State agency said it was reviewing payment levels to determine additional funding needed to adjust upper limits as part of its biennial budget preparation process. The State said it was committed to establishing a baseline for uniform periodic review of fees paid by Medicaid.

These efforts by the State, when completed, should help insure that the State does not exceed Federal upper limits on practitioner payments and also encourage providers to participate in Medicaid.

CHAPTER 7

NURSING HOME REIMBURSEMENTS BASED ON INACCURATE COSTS

Medicaid reimbursements to approximately 820 nursing homes in Ohio amounted to $182 million in the year ended June 30, 1977. This is the second largest category of Medicaid costs, representing about 33 percent of Ohio's total. The State calculates the reimbursements on the basis of costs which the nursing homes report. Ohio law requires that these reimbursements be based on reasonable costs of caring for Medicaid patients; however, Ohio lacks adequate assurance that reimbursements are based on this requirement or that costs reported are accurate or valid because:

--Ohio had not enforced the cost-reporting requirement and lacked an effective penalty for homes that fail to submit cost reports.

--Inadequate guidance to nursing homes had resulted in their submitting inaccurate cost reports.

--Reported costs were not verified by field audits and unaudited costs were used to establish the reimbursement rate structure for all homes.

--Ohio had made little progress toward meeting a July 1976 HEW requirement that a State must field audit all nursing homes within 3 years, ending no later than December 1980, and lacked an adequate plan to do so.

METHOD USED TO CALCULATE REIMBURSEMENT RATE

Nursing homes in Ohio are reimbursed on a prospective basis; that is, a per diem rate to be paid in the future is calculated for each home based on past costs. For example, costs reported for the 6 months ended December 31, 1975, were used to set rates for calendar year 1977. The nursing home's rate is then multiplied by the number of patient days at the home each month to determine the monthly reimbursement. Except in cases of misrepresentation of costs and/or services rendered or concealment of data which would indicate a lower rate than a home is receiving, the rate is not adjusted retroactively.

The average per diem rate for Ohio nursing homes was $19.32 in June 1977.

MANY HOMES DO NOT SUBMIT REQUIRED COST REPORTS

Since 1972 Ohio has required nursing homes to submit cost reports. However, it has neither enforced this requirement nor taken action to penalize homes that had failed to comply. We identified 301 homes that had not filed 1,038 required cost reports between January 1972 and December 1976. 1/ Most of the homes no longer participate in the Medicaid program because they (1) were terminated for such reasons as failure to meet health and fire safety standards or (2) withdrew from the program. None, however, were terminated for failing to submit cost reports. Some of these homes had been paid for several years without submitting cost reports.

While we could not determine how much Ohio paid these homes during the period in question, we believe a great amount of money was involved. One hundred and forty-seven homes had not filed any cost reports for 1975 or 1976. Three of these homes were still participating in the Medicaid program in June 1977 and were paid a total of $1.9 million during the 2-year period.

In June 1977, 77 of the 301 homes were still participating and were paid about $1.1 million. These 77 homes had failed to submit a total of 129 cost reports, and 3 of the homes had not filed cost reports since July 1974. Had these homes submitted cost reports, Ohio may have been able to reduce reimbursement rates and, thereby, Medicaid payments.

1/Beginning in 1972, nursing homes which wanted to be reimbursed on a cost-related basis had to file cost reports with the State. If a home did not file a cost report, it was paid at a State determined flat rate per-patient-day. All homes were required to submit cost reports after June 1974. The homes included in the total for the January 1972 to June 1974 period are ones that chose to be reimbursed on a cost-related basis and, therefore, were required to submit cost reports.

Cost reports were required to be filed within 90 days after the end of the reporting period. Failure to file a timely cost report resulted in a nursing home being paid at the same rate. The rate was revised when the nursing home submitted its cost report. If the report indicated the home was overpaid during the period for which it failed to file, Ohio reduced future payments until the overpayments were recouped. If the home could justify an increased rate, the increase was delayed by the number of months the required reports were late. We believe the State should penalize a nursing home when the home fails to submit a cost report, not when the home finally does submit one. If a nursing home expects to receive a rate reduction, the penalty of not increasing rates until a cost report is submitted is meaningless because the home has, in effect, an interest-free loan of State and Federal funds during the period between the required cost report filing data and a date sometime after the cost report is actually filed. Also, without cost reporting compliance, Ohio cannot implement a reimbursement system on a reasonable cost-related basis as required by State and Federal law. We believe a better penalty or incentive for timely filing of cost reports is needed.

INADEQUATE GUIDANCE RESULTS IN INACCURATE COST REPORTS

Because of inadequate guidance from the State, nursing homes have difficulty preparing accurate and complete cost reports. Generally, costs incurred for the care, comfort, and safety of patients are allowable provided the costs do not exceed established ceilings. Nursing homes need specific guidance to determine what costs are allowable and how they should be classified on the cost reports. Officials at most of the nursing homes we visited said that (1) they were not given specific written guidance on cost-reporting requirements by the State and (2) they were unaware of many policies regarding cost allowability. The State instructs nursing homes to use Medicare's reimbursement principles. There are exceptions to these principles; however, the State has failed to inform the homes of them. As a result, nursing homes have improperly prepared their cost reports which included misclassified and unallowable costs, and Ohio has calculated reimbursement rates on the basis of these inaccurate reports.

We examined selected costs at 10 nursing homes and found that these homes had submitted inaccurate cost reports.

In some cases written criteria did not clearly explain allowable expenses, while in others the Federal written criteria conflicted with unpublished State criteria. Furthermore, cost-reporting instructions did not adequately define what expenses can be included in the allowable cost items, so that nursing homes can convert their expense classifications from their accounting records to the cost categories on the cost report.

We believe that because of conflicting, unclear, and largely unpublished guidelines, nursing homes operate on the premise that it is better to report all costs and let the State disallow some, rather than not to report questionable costs at all. The potential for overpayments was high because misclassified and unallowable expenses cannot be identified merely by reviewing cost reports, and Ohio had no program for field auditing nursing home costs reports until February 1977. The following are some examples of misclassified and unallowable costs which we found had been reported.

One home reported entertainment expenses of $3,31 as advertising costs in its cost report. The nursing home accountant said he did not know where else to put it, since "entertainment" was not a separate line item on the report. The State regulations did not explain the classification or allowability of this expense. The head of the State agency's nursing home reimbursement unit informed us that a written policy on entertainment did not exist. To be reimbursed for these expenses, he said that the home must submit documentation on which he used the following criteria to determine allowability:

--Is the expense adequately documented?

--Is the expense patient related?

--Is the expense allowed by the Internal Revenue Service?

The nursing home accountant was not aware of this unpublished criteria.

Another home reported an advertising expense of $450 for an advertisement in a local business directory and an education expense of $600 for an administrator's continuing education seminar in Canada. The Medicare reimbursement

manual indicates that in this instance the advertisment and its distribution had to be analyzed to determine the allowability, while the State's unpublished policy disallows such an expense. The Medicare manual allows the continuing education expense, but the State's unpublished policy disallows it because the training was received outside of Ohio. The nursing home official did not know of this unpublished policy.

Another home reported an interest expense of $2,390 which should not have been allowed. We found that the home had interest income which should have been offset against this expense. Also, the interest expense was not related to patient care and should not have been in the cost report. The home also reported $1,647 in unallowable management fees. Although the criteria for these two cases are explained in the Medicare manual, the nursing home's executive director and accountant said that they were not aware of these policies.

Another home included costs of $25,600 on the line items for medical supplies and professional services. Our audit showed these were ancillary service costs, such as physical therapy and laboratory services, which are not allowable on the cost report. Medicaid regulations require that these services be billed directly by the provider of the services, not the nursing home. Both the home's administrator and accountant said they were unaware that ancillary services were unallowable, attributing this to a lack of State guidance.

One home filed costs of $701 on the "medical and/or rehabilitation professional services" line item for a "geriatric consultant". We found that this expenditure was for

--a physician visiting nursing home patients,

--a podiatrist visiting patients,

--an annual fee to a law firm for a Bureau of Workman's Compensation award won for a patient.

The physician and podiatrist visits and laboratory work were ancillary services which should have been billed directly, while the payment to the law firm was not an expense of the nursing home. Thus, the entire $701 expense was misclassified

and was an unallowable cost. The owner/administrator said that the home relied on its certified public accountant for proper cost reporting and assumed the accountant knew the applicable regulations since cost report preparation was the accountant's specialty. The owner had no knowledge of these regulations.

Although Ohio has disseminated the "Medicare Provider Reimbursement Manual" and the "Ohio Medicaid Handbook" and has given various seminars throughout the State, it still needs specific written guidelines. A State official informed us that the Medicare manual was sent to every nusing home in 1972, but updated revisions had not been distributed and copies had not been sent to nursing homes coming into the program since 1972.

Ohio has not give nursing homes adequate guidance on preparing cost reports. The instructions on cost allowability were inadequate. Nursing homes were told to "List the balances of operating expenses as recorded in the facility's financial records." We believe this has resulted in cost reports that reflect operating costs rather than allowable program costs.

Ohio officials agreed that nursing homes need better guidance on proper preparation of cost reports and cost allowability, but said the staff needed to prepare the guidance was not available.

Better guidance needed to manage patient personal allowance accounts

The county welfare departments are responsible for insuring that patients' personal funds are properly managed and that all expenditures are proper and supported by invoices or receipts. Eight of the 10 homes we audited maintained personal allowance accounts for Medicaid patients, but only 3 had properly recorded and supported expenditures.

Each Medicaid patient receiving care in a long-term facility can retain $25 a month for the purchase of his or her own personal items. These funds come from Social Security pensions, Veterans benefits, disability compensation, SSI, or contributions from relatives. The patients use this allowance to buy such things as clothing, cosmetics, hair styling, tobacco, newspapers, and other incidentals.

According to Ohio regulations, the funds are not to be used for covered medical supplies and equipment, physicians' services, or items of routine care to be provided by the nursing home such as soap, lotions, and tissues.

Each patient is allowed to manage his or her own account if capable of doing so; otherwise, arrangements are made for the nursing home or a third party to handle the patient's fund. When the nursing facility manages the account, it is required to maintain a ledger account of income and expenditures with dates, reasons, and receipts for each account maintained.

At five of the eight homes which maintained patients' funds, we found that some expenditures were improper and many were unsupported by invoices and receipts. Examples of some of these poor management practices were:

--At one home, $2,000 in patients' funds had been used between October 1975 and May 1977 for medical supply items, such as wheelchairs; another $1,400 was used to pay for physicians' services. These services are covered by Medicaid; therefore, patients' personal funds should not have been used.

--One home did not keep vouchers or receipts to support purchases for the period we audited and apparently posted items to patient accounts from memory.

--Two homes failed to follow State guidelines on applying funds to the cost of care when the balance in a patient's account exceeded $300. Instead of contacting the county welfare department so it could arrange to apply the excessive funds to a patient's cost of care for a month, unallowables, such as prescription drugs or wheelchairs, were purchased.

--Ledger accounts at one home did not show individual amounts expended each month. Instead, categories, such as candy and soft drinks, would show one entry for multiple purchases of a particular item. Apparently entries were made on scratch paper, then discarded when posted. Few invoices were available to support these expenditures.

--At one home, all 10 patient accounts showed a $3.00 per month charge for a package consisting of kleenex,

face soap, deodorant, toothbrush, mouthwash, and skin lotion--items clearly not allowable for deduction from personal allowance accounts. Ohio correctly considers these items to be part of routine care covered by the monthly reimbursement rate. Most of the purchases from patient accounts at this home were unsupported.

From these examples, it is clear that the county welfare departments did not provide sufficient guidance or monitoring to assure proper nursing home management of patient personal allowance account expenditures. Public law 95-142 requires the Secretary of HEW to define in the regulations what constitutes appropriate use of patient personal funds and how nursing homes have to account for their use. This should assist the State in assuring proper use of personal funds.

IMPORTANCE OF NURSING HOME AUDITS IN DETERMINING REASONABLE COSTS

Unless Ohio field audits nursing homes, it cannot determine if its reimbursements are based on the homes' reasonable costs for Medicaid patients. Ohio bases the reimbursement rate on costs reported by nursing homes. Without a field audit of the homes' records, the State cannot determine if the reports contain costs that are not allowable under Medicaid reimbursement principles. Our field audit of 10 homes' records showed that unallowable costs had been reported and, therefore, have been used by Ohio in establishing reimbursement rates.

Since 1974, Ohio has calculated the reimbursement rate by comparing nursing home reported costs to established line-item-cost-ceilings and overall cost ceilings. Ohio uses the lower of the reported costs or line-item-ceilings as the reasonable cost in determining the reimbursement rate. After adjusting for the line-item-cost-ceilings, Ohio compares the resulting cost per-patient-day to the overall cost ceiling and reduces to this ceiling if necessary.

Ohio established the line-item-cost-ceilings using unaudited costs reported by nursing homes. Ohio sampled the cost reports and established the ceilings at the 90th percentile of the reported costs. Because the reported costs were not field audited, unallowable costs may have been included and could have increased the line-item-cost-ceilings. This would inflate reimbursement rates.

Ohio officials said they did not know which homes were used to establish the line-item-cost-ceilings for 1977. Therefore, we were not able to field audit those homes, as we believe Ohio should have done, to determine if unallowable costs were included in the ceilings. However, even if the cost ceilings were based on audited costs, we believe it would be necessary to audit nursing home records because our field audits showed costs reported by homes not used to set the ceilings can be within the ceilings and still contain unallowable or unsupported costs.

The 10 homes were paid $3.1 million for care provided to Medicaid patients during the year ended June 30, 1977. Payments made during the last half of that year were based on costs reported for the 6 months ending December 1975. For that period, the homes reported total costs of $3.4 million. We examined selected costs totaling $1.2 million, or 35 percent of the total. We found that about $299,000, or 25 percent, of the reported costs examined were not allowable under Medicaid because they were either nonreimburseable, inflated, or unsupported. Ohio's line-item-cost-ceilings, however, disallowed only $180,000. Other criteria used by Ohio reduced reported costs by about $42,000. The following table illustrates the differences between the State's reduction and our reduction.

Unallowable Costs Identified in Audits of Selected Costs for Ten Nursing Homes

	Amount we found unallowable	Amount disallowed by Ohio ceilings	Difference
Nonreimbursable service costs	$243,073	$194,932	$48,141
Inflated costs	33,544	9,011	24,533
Unsupported costs	22,347	18,017	4,330
Total	$298,964	$221,960	$77,004

Examples of the types of erroneously reported costs which the ceilings failed to disallow follow.

--Line items for administrative salaries, education, advertising, and moving expenses which totaled $16,217, for one nursing home included expenses of $11,943 that

were unallowable for Medicaid reimbursement. However, Ohio's line-item-cost-ceilings reduced the total by only $1,985. Thus $9,958 in unallowable costs were missed by the ceilings.

--The same home erroneously reported about a year's salary costs when it should have reported salary costs for only the last 6 months of the year. The reported costs were $14,945 more than they should have been. Ohio's use of its line-item-cost-ceilings on the reported salary costs resulted in a reduction of only $1,167.

--Another nursing home understated the number of in-patient days by 359 for the last half of 1975. This caused an increase of $1.67 per-patient-day in the reimbursement rate and an estimated additional $7,000 in payments to the home for 6 months. The error, made by the nursing home's accountant, could not be detected by the cost ceilings because they are not designed to do so.

--The third home reported food costs of $47,457, well below its food cost ceiling of $60,310. However, the reported costs included a $10,461 food purchase of which about $8,000 had not been delivered as of the date of our audit (more than 16 months after the purchase) and thus, should not have been allowed. The total was allowed, however, because it was below the cost ceiling.

--A fourth nursing home included in its travel costs a $10 per week automobile allowance for 56 weeks instead of the 26-week (one-half year) reporting period. This mistake by the nursing home's accountant overstated travel expenses by $300 which, again, was well within the cost ceiling.

Ohio Medicaid officials agreed that the line-item-cost-ceilings should be based on audited costs but said that this would not be done until December 1978 after enough homes are field audited. Thus, it will be at least 1979 before ceilings based on audited costs will be used to calculate nursing home reimbursements.

NURSING HOME AUDIT EFFORT NEEDS IMPROVEMENT

Before 1977 Ohio had audited only three nursing homes. As of June 30, 1977, another 28 homes had been audited after additional staff had been hired and audit assistance had been obtained from an accounting firm under a State contract. Federal regulations, effective July 1976, require that States field audit all nursing homes during a 3-year period ending not later than December 31, 1980, with not less than one-third of the homes being audited each year. After 1980 onsite audits are to be done in at least 15 percent of the homes each year. The State agency will not be able to comply with the 1980 requirement because it lacks sufficient staff and money. In addition, the homes audited will not be used to calculate line-item-cost-ceilings until at least 1979. This will further delay Ohio in being able to base reimbursements to nursing homes on reasonable costs.

Ohio's nursing home audit effort

As of August 1976, only three homes had been field audited. Therefore, the State controlling board approved a request to hire 59 auditors so that more nursing home could be audited. The State hired 42 people but we were told that only 30 were assigned to nursing home work, and only 18 of these were assigned to audit nursing homes. Between February and April 1977, three homes were audited. In May 1977 an accounting firm began assisting the State in making audits and training State personnel in nursing home auditing. From May to June 30, 1977, an additional 25 homes were audited when the contract with the accounting firm expired.

As of May 1977, Ohio had approximately 820 nursing homes providing nursing home care to Medicaid recipients. As of June 30, 1977, only 31 homes had been audited. Assuming that nursing home audits can be done in 2 weeks, startup problems are eliminated, and 9 teams of 3 people each are used, 700 audits could be completed, or about 85 percent of the required number, by the end of 1980.

Ohio officials believed at the time of our fieldwork that they would not complete 700 audits by December 1980 because:

--From May to June 1977 one-third of the audit staff consisted of accounting firm personnel who are no longer available and Ohio did not have the people available to replace the staff.

--Overtime was needed to complete nursing home audits in 2 weeks each and funds were not available to continue overtime pay.

Ohio used several criteria to select the 31 nursing homes for its audit. Some homes were selected randomly and others were selected by exception; that is, the homes reported an occupancy rate of over 100 percent or had received a rate increase in excess of $3.00 per-patient-day. Other factors, such as usefulness in training personnel and convenience of location, were also considered. None of the homes were selected to improve the cost ceilings used in setting reimbursement rates.

Under its current procedure, Ohio will compute 1979 reimbursement rates from cost reports covering the last half of 1977. We believe that Ohio should act quickly to base its line-item-cost-ceilings on audited cost figures by first auditing those homes whose cost reports are used to determine these ceilings. The State will then have better control over all nursing home costs while the homes are being audited. Also, if Ohio does not act quickly to improve the line-item-cost-ceilings, it may place itself in a position of having to collect moneys it should not have paid because the ceilings would not have reduced unallowable costs reported by the nursing homes. We believe that Ohio's future nursing home audits should be focused on the homes selected to establish line-item-cost-ceilings.

Public disclosure of ceilings requires audits be completed as soon as possible

Before 1977, line-item-cost-ceilings were not made available to nursing homes and the operators did not know how their reimbursement rates were calculated. Ohio kept the ceilings confidential because increased program costs were expected to result if they were known. In January 1977, in response to nursing homes' requests to release the ceilings and in view of the planned initiation of audits, Ohio began releasing copies of the cost ceilings and reimbursement rates to nursing homes. These showed (1) how the

ceilings were applied to the December 1975 cost reports to determine the 1977 reimbursement rates, (2) how the ceiling maximums for each cost category were determined, and (3) identified any cost reductions applied to the filed costs.

We believe disclosing this information could result in a ballooning of reported costs that, while not exceeding ceilings, would require audits to determine their reasonableness. Using this information, nursing homes could estimate the line-item-cost-ceilings for reimbursement rates in 1978 and gear their spending to maximize reimbursements.

In June 1977, 49 skilled nursing facilities (SNFs) were being reimbursed at the $26-per-patient-day maximum, and 29 intermediate care facilities (ICFs) were being reimbursed at the $22 ceiling. Although these reimbursement ceilings--mandated by Ohio law--override the individual cost ceilings, the release of individual cost ceilings will probably result in more homes reaching these overall ceiling reimbursement rates.

One Ohio official stated that the line-item-cost-ceilings only reduce reimbursements for luxury items and serve to curb excessive spending. In addition, he stated that these cost ceilings would allow reimbursement rates up to $40 per-patient-day were it not for the $22 and $26 reimbursement ceilings. However, we noted that by claiming the maximum amount allowed on each line item, the cost ceilings would allow up to $80 per-patient-day.

We believe the disclosure of the line-item-cost-ceilings to nursing homes, whose reimbursement rates are a function of filed costs rather than reasonable costs, makes the timely completion of nursing home field audits more urgent, especially for homes used to compute the cost ceilings.

CONCLUSIONS

Federal Medicaid regulations require that nursing home reimbursements be on a reasonable cost-related basis. Ohio does not reimburse nursing homes on this basis because it has not determined what the reasonable costs are. Nursing home field audits to assure that reported costs are accurate and valid had not been given high priority. Field audits have been initiated in response to Federal requirements.

An important step in the nursing home reimbursement program is the submission of cost reports by nursing homes. Without cost information, a State does not have an adequate foundation for administering a reasonable cost-related reimbursement program. Many of Ohio's nursing homes have been allowed to participate in the Medicaid program without submitting required cost reports. The State used a penalty for not reporting costs that did not affect homes not anticipating a rate increase. We believe that Ohio needed to implment a financial penalty for failure to submit cost reports that immediately affects reimbursement rates. When nursing homes do not report their costs to Medicare, that program reduces its payment rates.

Guidance provided to nursing homes regarding cost report preparation had been inadequate. As a result, Ohio received improperly completed cost reports that contain unallowable, misclassified, and unsupported costs. The quality of cost reports will not improve until proper guidance is given to nursing homes.

We believe that Ohio should develop and distribute comprehensive State policies rather than relying solely on Federal guidelines that were meant to help States develop their own policies. In particular, Ohio should instruct nursing homes on how to obtain allowable Medicaid program costs from accounting records to insure that cost reports reflect reimbursable program costs rather than operating costs.

There was a need for better guidance for nursing home patient personal allowance accounts. County welfare departments are responsible for monitoring the management of personal allowance accounts through quarterly onsite reviews. Since five of eight nursing homes did not properly manage these accounts, we believe that the county welfare departments have not provided sufficient guidance or properly monitored patients' personal allowance accounts to assure that expenditures are properly and adequately documented.

The line-item-cost-ceilings Ohio uses to determine reasonable nursing home costs are based on unaudited cost figures. Nursing home field audits completed or planned for the near future will not help to improve these ceilings. Because Ohio will not be able to complete its audits for several years, we believe that nursing home cost reports

selected to provide new cost ceilings should be given first priority. The State will then be able to control the costs of all nursing homes with ceilings based on audited cost figures, while it is auditing specific nursing homes.

Ohio needs to field audit all Medicaid nursing homes before the December 1980 Federal deadline expires, however, it does not appear that Ohio will be able to meet the deadline. It should be recognized that the disclosure of the line-item-cost ceilings to nursing homes places increased importance on the need for Ohio to complete the audits as soon as possible. We believe that Ohio should assess its audit capability to determine what additional resources are necessary to comply with the Federal deadline and then obtain sufficient resources.

RECOMMENDATIONS

We recommend that Ohio:

--Field audit, on a priority basis, those nursing homes whose cost reports are used to develop new cost ceilings.

--Assess its audit capability to determine what additional resources it needs to comply with the Federal 1980 field audit deadline and then obtain sufficient resources.

AGENCY COMMENTS

The State agency said it had completed audits of 131 nursing homes as of April 28, 1978, and had contracted with a public accounting firm to design a computer program which will enable the State to (1) identify nursing homes meriting field audit effort, (2) set more valid screens and limitations, and (3) provide a higher level of speed and accuracy for the rate setting process. The State also said teams of State employees have been established to audit patients' personal accounts.

Regarding our recommendation to field audit on a priority basis those nursing homes whose costs reports are used to develop cost ceilings, the State agency said it believed that auditing large homes, where the amount of audit exceptions are likely to be greater, would be more beneficial at this time. The State agency said that it

believed our recommended approach would be worthwhile after 1980 when Ohio will audit 15 percent of the nursing homes each year.

As stated on page 71, we believe that by auditing those homes used to calculate cost ceilings, the State would be better able to control payments to all nursing homes. Also, since the State should have audited all homes by the 1980 deadline, the auditing exceptions at larger homes would still be identified by then.

The State agency has also implemented two of our proposals.

--The State agency has implemented a penalty for nursing homes which fail to submit cost reports. Fifty-four nursing homes had their rates reduced when they failed to fill cost reports on time. Fourteen of these homes were subsequently terminated from Medicaid participation for failure to submit cost reports.

--The State agency has issued comprehensive instructions to nursing homes including a standard chart of accounts which should help minimize the misclassification of expenses.

These actions should help improve the State's control over the nursing home rate setting process.

CHAPTER 8

BETTER PROCESSING CONTROLS NEEDED IN PAYING MEDICAID CLAIMS

During the year ended June 30, 1977, excluding long-term care services, Ohio paid 14.9 million claims to 20,700 providers of Medicaid services. These payments totaled $376 million, or about $1 million a day. A computerized claims processing system checks these claims to assure that the claims are for covered services, provided to eligible recipients by eligible providers, and paid at the authorized amounts. Because of system deficiencies, the claims processing system can pay claims that are inaccurate and/or invalid. For example, failure to check dental invoices to assure that claims for dental X-rays did not exceed the State limit of $15 per-patient-per-year resulted in overpayments of $553,000 during the 3-year period ended December 31, 1976.

Further, lack of controls over computer program documentation and testing jeopardized the system's reliability, caused administrative inefficiencies, and increased the possibility of fradulent or accidental misuse of Medicaid funds. For example, during the first 6 months of 1977 a provider eligibility edit was accidently deleted by the State when a program was modified but not tested to insure proper operation. Thus, for a period of time, the State did not have an effective computerized provider eligibility edit.

The Ohio claims processing system generates data that is used for more than 20 reports produced by the Management and Administratiave Reports subsystem (MAR) of the State's Medicaid Management Information System (MMIS). These reports are distributed to various State Medicaid personnel for their use in managing the Ohio Medicaid program.

OHIO MEDICAID CLAIMS PROCESSING SYSTEM

The Medicaid claims processing system is one of six subsystems in the Ohio MMIS which has been certified by the Department of Health, Education, and Welfare. The MMIS was developed under HEW guidance to (1) facilitate prompt and accurate payment of claims for medical care (claims processing), (2) provide and organize information for improved Medicaid program management through MAR, and (3) provide

reports for reviewing the use of medical care paid by the State for Medicaid recipients through the Surveillance and Utilization Review subsystem (SUR). The adequacy of SUR reports is discussed in more detail in chapter 9.

The computerized claims processing system processes all providers' claims, except for long-term care providers who are reimbursed monthly based on an established per diem rate as discussed in chapter 7. All other providers are reimbursed on the basis of invoices submitted to the State for services. These services include drugs, medical equipment, laboratory tests, hospital services, and services by doctors, dentists, and other medical personnel.

The process of paying individual claims consists of five major functions--claim receipt, claim input, computer processing, correction of errors, and State Auditor's review. The actual comparison of the provider's invoice against various requirements and limitations is done through computer programs during the computer processing segment. The computer programs organize the data into computer workable formats, and check (edit) the submitted data for compliance with the requirements which have been programed into the system.

OUR TESTS OF THE CLAIMS PROCESSING SYSTEM

To determine the ability of the computer system to properly edit invoice data, we developed and processed a test deck consisting of 261 claims through the system. The test included four types of claims (dental, outpatient hospital and clinics, pharmacy, and physician) that accounted for about 90 percent of calendar year 1976 claims. We tested 60 of the 102 edits that applied to these four types of claims. Most of the 60 edits concerned checks on the eligibility of recipients and providers and the validity of the services provided.

Although 88 percent of the claims in our test deck were properly processed, we found that claims containing errors were not always identified by the claims processing system. We identified 10 edits, already programed into the system, which failed to detect the errors in the situations created by our test. We also noted that six additional edits would be needed to detect other types of errors contained in our test deck. However, the cost effectiveness of programing and using these six edits is questionable.

The most significant types of errors were (1) claims in which the diagnosed problems and/or the medical procedures performed were inconsistent with the recipients' age or sex, (2) claims where the procedure performed was inconsistent with the diagnosed problem, (3) duplicate claims, and (4) the lack of minimum drug dispensing quantities.

The lack of edits or improperly programed edits resulted in a failure to enforce State policies and meet HEW minimum standards for certification of MMIS.

Computer edits do not adequately enforce State policy

The Ohio Medicaid handbook lists State policies on covered services and on service and payment limitations. However, our test of selected State policies showed that some were not being enforced through prepayment computer edits. For example, since 1972 the Ohio Medicaid handbook has limited payments for dental X-rays to $15 per-patient-per-year. However, the computer did not have edits to assure that payments did not exceed the $15 limit until February 1977. An analysis of claims paid during the 3-year period ended December 31, 1976, showed Ohio paid $552,745 for claims exceeding the $15 limit.

Other State policies which we found were not adequately enforced by edits were:

--Prescription refills cannot exceed 6 within a 6-month period. A computer edit screens the history file for violations, but not the current processing batch. State officials agreed that the current processing batch should be checked.

--Prior authorization should be obtained for selected dental work. The procedure codes which are checked by the program for prior authorization do not include all of those listed by the State.

--A dental periodic examination should not be paid within 6 months of an initial exam. A test invoice was processed that paid for both an initial and a periodic exam performed on the same day.

--A dental exam cannot be paid within 6 months of another dental exam. A test invoice was processed that paid for a periodic exam 40 days after a claim for another exam because dental edits do not check all claims within a processing batch or cross-link the two edits to assure that dental exams are at the proper time intervals.

--Only one dispensing fee should be billed for each month's supply of each medication used on a continuing basis. Ohio has no edit to enforce this policy. State officials believe this policy is best enforced on a postpayment basis by checking physician prescribing patterns.

Since we did not attempt to determine if all State policies are or can be enforced by edits, we do not know if additional edits are needed or if other programing corrections are needed. State Medicaid program officials could not tell us which policies were or were not enforced by edits but stated that prepayment edits were often not cost effective. They believe some State policies could better be enforced through postpayment surveillance and utilization review but could not identify which policies should be or are being so enforced.

Edits do not meet HEW standards

HEW certified Ohio's MMIS as of October 1975. We found, however, that Ohio's claims processing system fails to adequately meet some of the minimum standards defined in HEW's certification criteria.

HEW has specified over 40 general checks that should be part of each State's MMIS. Ohio has not incorporated all of these edits or it has not performed the edits adequately. Some of the required edits not performed adequately in Ohio's system are:

--Medical or surgical procedures must be consistent with a recipient's age. A test invoice was processed that paid for fluoride treatment for a baby. Ohio has 2 edits that check age, but they cover only 25 procedures. The State of Washington checks about 400 procedures which indicates Ohio could do more.

--Medical or surgical procedures must consistent with place of service. A test invoi was processed that paid for major heart surgery in e recipient's home. The Ohio place of service edit does not cover all appropriate procedures.

Some required edits missing from Ohio's system are:

--Diagnosis must be consistent with the recipient's sex. A test invoice was processed for a man receiving treatment for a menstrual problem.

--Numeric items with defined upper and/or lower limits should be within the proper range. Birth control pills are normally dispensed in quantities sufficient for at least a 1-month supply, but a test invoice was processed for payment of less than a full month's supply. The computer is programed to allow a minimum dispensing quantity of one for all drugs. Another test invoice was processed that paid for a single pill. Also, a test invoice was processed that paid for a prescription exceeding the maximum dispensing quantity.

--Service dates of institutional claims should not overlap. Nursing home claims were processed separately from the normal claims processing system used to process hospital claims and the two were not compared to check for overlapping service dates.

--Reimbursements to providers should be limited to a practitioner's usual and customary charges. As mentioned on page 51, Ohio did not obtain data on usual and customary charges.

LACK OF CONTROLS OVER COMPUTER PROGRAM DOCUMENTATION AND TESTING

To reflect changes in HEW and State Medicaid regulations, frequent changes are made to the computer programs used to process and pay Medicaid claims. These computer programs are designed to review the providers' invoices for completeness and accuracy and are the most important part of the claims processing system. Therefore, the State should control the development, revision, and use of the computer programs to assure that they are protected from unauthorized changes and destruction. Also, program changes

should be documented so that audit trails are available when future changes become necessary. Program changes should also be tested to insure that the changes actually accomplish what is intended and do not create problems in other parts of the computer operation.

Controls over computer programs were not adequate and programers often failed to update the system's documentation or adequately test programs before they were used to process claims. Typical of the problems caused by these weaknesses are the following examples from our test deck of improperly processed claims due to improperly programed edits:

--The computer processed one claim for a provider who was ineligible when the service was provided. This error resulted from an untested change to a program.

--Another claim was processed for payment when an invalid prescribing physician number consisting of all zeros was present on a drug claim. Since a provider number of all zeros is not valid and Ohio has an edit to check on the validity of provider numbers, that edit must have been improperly programed.

Control over development and changes to computer programs are inadequate

Ohio Medicaid officials do not have adequate controls over the development of and changes to computer programs. For example:

--Review and approval by senior management and applicable users of new programs and program changes were not always accomplished.

--Programs were often not documented and fully tested.

--Updating material for the program procedures and operations manual was not always performed.

As a result, changes to computer programs could not be traced from the t e the program is added to the claims processing system to the latest change in the program. Programers did not need authorization to change programs, and documentation of the change was not required.

The only control over changes to computer programs was an assignment task sheet. This document identifies how and when changes are made and provides for review and approval by senior management personnel. A State official said, however, that because programers did not always use this document, the audit trail for program changes was incomplete.

For example, we identified a computer program that was not (1) reviewed or formerly authorized by senior management personnel, (2) documented, (3) known to computer operations personnel, or (4) listed as a part of the flow chart describing the system.

As far as we could determine, only the programer knew of the program. Fortunately, this program was used to develop reports rather than to pay claims.

We also identified another instance of a program change not being documented. Since August 1972 State policy has limited full mouth X-rays to 1 every 3 years. Ohio officials could not provide documentation showing when the edit to enforce this policy was programed into the computer, but they said claims had been edited for this since early 1977.

Program documentation is unreliable

The claims processing documentation was unreliable in that

--it did not describe what the program was designed to do,

--it was not updated consistently and was inaccurate, and

--documentation requirements were not always properly enforced by management.

As a result, the State could not use the documentation to properly manage the claims processing system.

Adequate documentation of computer systems, programs, and operating procedures is necessary for a complete and accurate understanding of computer processing activities. Ohio's documentation could not be used to

--provide management with a clear understanding of system objectives, concepts, and output and to insure that its policies are being carried out;

--serve as a basis for review of accounting and internal controls by internal and external auditors; or

--provide a convenient reference for system analysts and programers responsible for maintaining programs.

Ohio did not have written procedures requiring that all programs be properly documented or a method to insure that all documentation was prepared in accordance with predetermined standards. Ohio's documentation did not always include an adequate description of systems, program flow charts, programs, examples of inputs and outputs, operating procedures, test decks, or record layouts. We believe documenting changes as they are made is more efficient than attempting to reconstruct the documentation later.

We attempted to obtain program documentation to perform our data retrieval projects and prepare our test decks. We were hampered, however, because some program documentation was inadequate, inaccurate, or missing. For example, documentation describing the contents of the master claims history file, a history of all Medicaid claims from 1972, indicated that the file contained the secondary diagnosis code. However, when we attempted to use this file for audit retrieval and analysis, the file printout did not show the secondary diagnosis code and we had to reprogram the request and obtain the data from another file.

Computer programs are not adequately tested before use

Before implementing new or revised programs, the program should be tested to assure that it works properly. Program test procedures should be governed by written instructions and should involve common sense precautions. Testing should (1) include a variety of conditions, (2) include improper and proper data to see whether the controls are functioning, and (3) test a series of related or interlocking programs to assure that the change will not adversely affect other programs. Testing of new and revised programs should be required, properly authorized by supervisory personnel, and the results of testing adequately documented and reviewed by someone other than the programer before the program is operationally used.

Although numerous modifications are made to the computer programs used to process claims, Ohio had no formal written testing procedures, no test data on which program modifications could be tested, and no requirement for independent certification that new programs or modifications are correct. Lack of documentation hindered us from developing reliable statistics on the number of times programs have been modified. However, during the period July 1976 through January 1977, 46 changes were made to a program that produced a printout identifying the frequency and type of errors found in claims processed. These 46 changes resulted from changes to the programs that edit claims. In most cases, we could not document that the changes were tested.

Without testing the changes, the State cannot be assured that program modifications will accomplish what they should and, more importantly, will not adversely affect some other part of the processing cycle. For example, the State, while attempting to change a program to link Medicaid and Medicare provider numbers, accidentally deleted an edit to check the provider's eligibility. As a result, from January through May 1977, the claims processing system was not adequately verifying provider eligibility. Computer programing personnel indicated that the error occurred because no one tested the program.

MANAGEMENT AND ADMINISTRATION REPORTS

The Ohio claims processing system generates data used to prepare more than 20 MAR reports. These reports are distributed to various State Medicaid personnel for their use in managing the Ohio Medicaid program.

The MAR reports appear to be generally providing management with the data they need. Most of the personnal receiving these reports said they use some or all of the reports. One office did not fully rely on the data in the reports because the data (1) was not consistent among the reports and (2) did not agree with data in other reports maintained by that office. Different cutoff dates were cited as the main reason for the differences.

CONCLUSIONS

Ohio does not know whether all its policies are being enforced through edits. The State's failure to effectively

use edits to enforce policies has resulted in payments to Medicaid providers over and above what the State intended. Ohio's system also lacks edits required to meet the HEW minimum standards for certification of MMIS, yet it has been certified by HEW.

Ohio's control over documentation and testing of claims processing computer programs is inadequate and has hampered its ability to manage payment operations and may be allowing payment for services not covered by Medicaid. Weak controls also expose the claims processing system to potential fraud or misuse of Medicaid funds by claims processing personnel.

RECOMMENDATIONS

We recommend that Ohio:

--Identify, document, and test existing edits to assure they are performing as intended.

--Analyze State policy to see if additional edits should be added.

--Develop indicators for surveillance and utilization review for those State policies that are not edited on a prepayment basis.

--Develop a system to test computer programs and certify their adequacy before using them for actual claims processing.

--Develop better security controls over development and changes to computer programs.

AGENCY COMMENTS

The State Medicaid agency agreed that improvements could be made in its edits and system documentation. In response to our recommendations, the State agency said it

--would add additional items to the lists of services covered by edits for sex, age, place of service, and minimum/maximum drug quantities if warranted by the results of a further detailed review of these edits;

--would review State policies and changes to policies to determine if edits to enforce policies would be appropriate;

--had identified all error codes as to whether they are for prepayment or postpayment review;

--has required changes in computer programs to be approved by management officials and tested before use for claims processing;

--has installed additional security controls over the development of and changes to computer programs;

--has begun to use the usual and customary charge screen capability of its claims processing system; and

--is using manual prepayment edits on about 25 percent of all claims types including ones for the dental X-ray problem discussed on p. 78.

These actions should help improve the reliability of the claims processing system.

The State agency also said that actions have been taken to recover all overpayments related to dental X-rays.

The State agency said it believes the primary purpose of system documentation is to aide the programer or analyst in understanding the system and that present documentation is adequate for this purpose. As discussed in this chapter, (see pp. 82 and 83), we believe that the documentation at the time of our fieldwork was not adequate for this purpose.

CHAPTER 9

CRITERIA AND STANDARDS NEEDED TO IMPROVE EFFECTIVENESS OF SURVEILLANCE AND UTILIZATION REVIEW

Federal regulations require States to establish and implement a statewide surveillance and utilization control program that safeguards against (1) unnecessary utilization of care and services and (2) excessive payments. The program is also to assess the quality of care and services provided. For ambulatory services, Ohio uses its Bureau of Surveillance and Utilization Review to conduct utilization reviews. Little of the Bureau's efforts have been directed at determining the quality of ambulatory care. The Ohio Department of Health does certify for the State agency independent and free standing ambulatory care clinics.

The Bureau uses the output of the Medicaid Management Information System's Surveillance and Utilization Review subsystem as its primary data source for identifying potential cases of program abuse or misuse. The reliability of these data largely depends on the computer edits in the claims processing subsystem and the accuracy with which medical diagnoses and procedures are coded on payment claim forms by providers. Problems in both of these areas cast doubt on the validity and reliability of the data base used by SUR.

The Bureau has identified many different types of potential misuse or abuse by both providers and recipients and has initiated several audits for suspected fraud. In spite of these efforts, the Bureau has had limited success in sustaining findings of abuse and misuse due to the lack of firm criteria and standards regarding what constitutes abuse or misuse.

Our independent review of utilization showed numerous patterns of service that appeared to have the characteristics of potential abuse or misuse. However, we were unable to conclude that the Medicaid services paid for were not rendered or medically necessary because we also lacked specific criteria or standards.

In an attempt to determine if additional techniques could be used to better assure that quality care is provided and abuse and misuse prevented, we used a technique designed by Utah's Professional Standards Review Organization (PSRO) for prepayment utilization review of ambulatory services. As a result, we identified a significant number of instances of questionable quality of care and potential over use of services. We believe a similar system could be beneficial to Ohio's Medicaid program.

The State has or is planning to implement several new methods to help control the utilization of Medicaid services. These include the monthly explanation to recipients of medical services paid by Medicaid, a lock-in policy to restrict recipients who overuse the program to one physician, and a revised medical assistance card. We believe that these actions will help control utilization of Medicaid services.

FEDERAL SUR REQUIREMENTS

Federal regulations require States to establish and implement a statewide surveillance and utilization control program that not only safeguards against unnecessary use of services and excess payments, but also assesses the quality of such services. This system must include a continuous program of review of the use of care and services which provides:

--Ongoing evaluation, on a sample basis, of the necessity for and the quality and timeliness of the services provided to eligible recipients.

--A post-payment review process that allows for the development and review of recipient utilization profiles, provider service profiles, and exception criteria. The process should also identify providers and recipients whose utilization patterns are aberrant so that misutilization practices can be corrected.

PROGRAM DESCRIPTION

The SUR program was monitoring 155 different statistical indicators in its analysis of physician Medicaid utilization. The number of indicators for other types of providers ranged from 18 to 120. Many indicators are common to several or all types of providers. Examples of some specific indicators that were reviewed routinely follow.

Provider indicators	Recipient indicators
Dollars paid	Dollars paid
Recipients served	Number of different diagnoses
Office visits	Different physicians seen
Office visits per recipient	Different optometrists seen
Injections per office visit	Prescriptions by:
Diagnostic services rendered	total
Prescriptions written	narcotic
Ratio of prescriptions per office visit	psychothropic
	analgesic
Therapeutic procedures	Transportation services
Pathology procedures	Podiatric services
Lab services ordered	

The SUR reports identified over 15,000 recipients who had patterns of medical services that exceeded the exception limits for such services for a 15-month period ended December 31, 1976. For the same period over 4,000 providers were identified because the services they rendered exceeded the exception limits established for the provider indicators.

The Bureau's primary criteria for identifying abuse and misuse is exceptional provider or recipient activity as compared to others in their peer group. For example, if a provider averaged 4.1 office visits per-recipient-per-month and the overall average for the peer group was 1.4 visits, he/she would automatically become suspect for abuse or misuse. This specific category of abuse is called "yo-yoing" (the provider has the patient return for apparently unnecessary office visits). Another example would be a recipient who saw six different physicians during the period compared to the recipient's age group average of two different physicians. Again, the recipient would be flagged as a potential abuser or misuser. In this instance the recipient would be suspected of "doctor shopping."

Once the computer analysis of the statistical indicators identifies the "exceptional" providers and recipients, Bureau staff reviews the exception output to determine if the provider or recipient should be noted for future followup and whether more detailed reports are necessary. If the SUR data is insufficient to resolve the question of whether the care provided or received was acceptable, a field investigation may be undertaken. If an investigation finds apparent fraud or abuse, the Bureau staff will attempt to recover the

erroneous payments. Also, if fraud is involved, the case may be referred to the appropriate law enforcement authorities for prosecution.

Under the Ohio SUR program all analyses are made on paid claims. Providers and recipients are classified into peer groups--providers by type of service and location of practice and recipients by age. Providers and recipients who exceed group norms by a predetermined amount, are flagged as potential abusers and/or misusers. The SUR subsystem routinely produces 20 reports which can be classified into three categories.

(1) General reports give data on services provided and rendered for the whole Medicaid program or for a specific recipient age group or provider class.

(2) Statistical reports contain data, such as averages, upper limits, lower limits, and frequency distributions.

(3) Detailed reports provide information on the services received by a specific recipient or rendered by a specific provider.

Special reports which are designed for nonroutine analysis are also available on request. For example, Bureau staff may want to know how many vitamin injections were given during a specific period or how many gall bladder surgeries were performed in a given geographic area.

The SUR subsystem produces a voluminous amount of data relating to medical services provided to recipients under the Medicaid program. However, some of this data is not used by the Bureau. For example, the Treatment Analysis Report is designed to assist in the discovery of overutilization by physicians and hospitals. The report was used extensively to identify overutilization of hospitals, but Bureau staff informed us that the data was not meaningful for physician review.

Also, the Bureau quarterly receives Provider Summary Profiles for all types of providers. At the time of our fieldwork, the Bureau reviewed this report only for physicians. All other provider types were reviewed only when specific abuse was suspected from tips or allegations. A Recipient Summary Profile is also provided every 6 months.

This report is voluminous and contains detailed information on all recipients who exceed exception limits. This report was used minimally in the past by the Bureau, but the Bureau planned to use it more extensively with the lock-in policy which is expected to be implemented by the end of 1978. (See p. 107.)

Reliability of SUR data base

Data used in the SUR subsystem comes primarily from the claims processing subsystem. Therefore, the reliability of the data largely depends on the computer edits in the claims processing subsystem. As discussed in chapter 8, there are questions on the effectiveness of some of the [illegible] processing edits. Also, a number of edits are not used, such as diagnosis to sex and procedure to age comparison edits, which would be beneficial in screening data which is input to the SUR subsystem.

In addition to the questionable quality of the claims processing data, we found that the manner in which medical diagnosis and procedure codes are recorded by providers on payment claim forms cast additional doubt on the validity and reliability of the data that eventually forms the basis for the SUR program.

The payment of a claim to a provider of Medicaid services is accomplished through the use of a State medical services invoice. For each service provided there is a procedure code which enables the service rendered to be entered into the claims processing system. Other information about a specific provider category is also included on the invoice, such as tooth number for dental invoices.

We observed that billing clerks are often responsible for assigning procedure and diagnosis codes from information on the recipient's medical chart. These clerks, who may or may not be medically trained, review medical charts, code the claim form for procedures (office visit, injection, laboratory test, etc.), and, based on these procedures, assign a diagnosis code (upper respiratory infection, anxiety neurosis, etc.). The claims processing system has few edits which identify procedure codes that conflict with diagnosis codes. As a result, many individual medical services, or patterns of services, that would ordinarily be questioned as potential abuse or misuse probably are not identified.

At one provider we noted that a cycle billing system was in use whereby office personnel would bill for services provided to recipients about once a month. All procedures for services provided to a recipient during the cycle would be claimed on one invoice with only the prevailing diagnosis given. As a result, conflicting diagnoses and procedures were billed, paid, and entered into the claims history system. For example, a claim for a recipient was coded with a diagnosis of anxiety neurosis but services received were a chest X-ray, pap smear, and a vaginal irrigation. In another instance, a diagnosis of hypertension was listed when the recipient received a foot X-ray. In still another instance the diagnosis was listed as rheumatism on the claim form when the recipient received a pregnancy test.

These examples, which resulted from this provider's billing practices, illustrate the "bad data" that can be included in the treatment analysis report and physician and recipient profile reports. Bad data such as these appear to show obvious abuse of the Medicaid program. Also, because of this bad data it would be impossible to review the quality of care provided to a recipient without checking the provider's medical records for the recipient. When we checked provider records, all of the examples given above were satisfactorily explained.

In commenting on our report, the State agency said that the experience of Bureau personnel is that the SUR data base is valid and reliable. As discussed above, we did not find the data base to be so.

BUREAU ACTIVITIES

The Bureau's ongoing evaluation of the necessity for the services provided under the Medicaid program has been in effect since March 1971. As of August 1977 the Bureau had 34 professionals. However, none were physicians and only a few had any medical background, such as a registered nurse or a licensed practical nurse. Therefore, the Bureau contracted with several physicians and other medical professionals to provide consulting services.

The Bureau identifies potential misuse by recipients and providers through a review of exceptions provided by the computer analysis previously described. Allegations of potential fraud or abuse are also used to initiate reviews. The Bureau also field audits providers suspected of potential

fraud, abuse, or misuse and it also monitors on a continuing basis, about 500 providers whose utilization patterns are suspect.

The Bureau has identified many different types of potential misuse or abuse by both providers and recipients. Also several audits for suspected fraud have been initiated. In spite of these efforts, the Bureau has had limited success in sustaining findings of abuse and misuse due to the lack of firm criteria and standards as to what constitutes abuse or misuse.

Monitoring and field audits

The Bureau was continually monitoring about 500 providers who, based on the computer analysis of paid claims, could be misusing the program. Some recipients also were subject to this monitoring. For this type of monitoring, Bureau staff scans the reports to obtain summary data about potential misuse and prepare and file a card to summarize the data. This monitoring, in conjunction with third-party allegations, is the basis for initiating field audits. One problem with the SUR computer analysis was that it did not identify, as groups, physicians engaged in group practice. This practice makes effective monitoring of group practices more difficult because total data on each group is not accumulated in one place.

Some examples of the Bureau's field audits follow.

Osteopathic Groups - The Bureau's initial audits were of two osteopathic groups. The first was based on an allegation that physicians were not adequately supervising physical therapy treatments being administered by their staff. The Bureau's field audit did not substantiate the allegation but it did find duplicate billings to the Medicaid and the Workmen's Compensation programs. The Bureau turned the case over to the State Auditor's Office for further review. The other audit was initiated after a newspaper article, based on an HEW press release, on alleged abuse by a pharmacy associated with an osteopathic group practice. The Bureau had been monitoring the group and began auditing the group and the pharmacy. The group practiced in a low-income area and received more Medicaid payments than any other group in Ohio. The Bureau staff decided to sample a number of areas, such as office visits, hospital visits, and so forth. This group was being monitored because Bureau analysis showed

--prescriptions for cough and cold preparations were about 16 to 20 percent of total prescriptions compared to the peer group average of 12 to 13 percent,

--prescriptions per recipient were three times the peer group average,

--radiology procedures were nine times the average, and

--injections per visit were twice the average.

Dentists - At the time of our review, the Bureau had initiated five dental audits. The State's dental consultant requested two of these audits because the dentists were doing root canals on the teeth of children, which would eventually fall out. The Bureau is collecting $33,000 from one dentist, and the other case has been turned over to the State Auditor. Two other audits were based on recipients' complaints that services paid by Medicaid were not performed. One of these dentists was convicted of grand theft and was terminated as a medical provider, the other case has been turned over to the Ohio Highway Patrol for further investigation. The fifth audit was initiated when a recipient complained about poor quality of service. This case was still being reviewed at the time of our fieldwork.

Podiatrists - In late 1975 the Bureau began to audit two podiatrist groups and three individual podiatrists because the Bureau's podiatrist consultant suspected abuse in the form of excessive visits and services ordered. Findings against one group totaled $44,500. The case was subsequently forwarded to the Attorney General for legal action in January 1977 and as of August 1977 was not resolved. The Bureau has collected $26,800 from the other podiatrists.

Pharmacies - The Bureau has conducted several field audits of pharmacies. One of the audits was part of the osteopathic audit previously discussed. Another field audit of a large drug store chain was initiated when it was noted that pairs of prescriptions were billed on behalf of the same recipient 2 or 3 days apart. This audit led to a State court requiring the firm to refund over $520,000 to the State.

In addition to field audits, the Bureau conducts special studies of selected areas as circumstances arise. For

example, when the pharmacy consultant suspected certain excessive billings, the Bureau initiated a special study of specific drug charges for 499 pharmacies. As a result, the Bureau identified over $22,000 in excessive charges for a 15-month period.

In another study the Bureau reviewed physicians who appeared to be overcharging for visits to more than one patient in a nursing home on the same day. The Bureau sent letters to 90 providers who were involved to a minor extent in these multiple visits. The letter reexplained the State's policy regarding billing practices for such visits; that is, reduced charges for each recipient seen after the first one. Eight additional providers were identified as abusers and notified that recoveries were to be made ($2,076 was identified of which $1,245 had been collected).

A third study of inpatient hospital services related to limitations placed on hospital services. Certain limitations were mandated by the Ohio Legislature and the Bureau was given responsibility for reviewing paid inpatient hospital invoices rejected by claims processing for

--Friday and Saturday admissions,

--Sunday and Monday discharges, and

--preoperative admissions longer than 1 day prior to surgery.

For the period from November 1976 through January 1977, the Bureau identified potential overpayments totaling $909,100 to 205 hospitals throughout the State, but recovering these payments will be difficult due to legal and medical questions as to whether the State can withhold such payments.

Recoveries resulting from SUR activities

The Bureau reported potential recoveries of $475,639 in fiscal year 1976. However, the Bureau did not know how much of this was actually recovered nor could it identify the kinds of services which were represented. For the April to June 1977 period, the Bureau reported that over $2.6 million had been identified for recovery. Of this $2.6 million, $1.1 million is estimated potential findings for

which no recovery had been sought. Of the remaining $1.5 million filed for recovery, about $523,000 had actually been collected. In addition, several cases were referred to the Attorney General, to county prosecutors, or to the State Highway Patrol.

OUR FIELD REVIEW OF MEDICAID PROVIDERS

We independently field reviewed four providers to determine if potential instances of abuse or misuse of Medicaid services represented fraudulent activities. We used data available in the SUR subsystem. Although our review showed numerous patterns of service that appeared to have the characteristics of potential abuse or misuse, we found no cases of fraud. The types of potential abuse and misuse we found are discussed below.

We also identified a weakness, a lack of necessary edits, in the claims processing system which allowed excessive dental X-ray charges and resulted in overpayments of $522,745 for calendar years 1974 through 1976. (See pp. 100 and 101.)

Physicians

Since the SUR computer analysis does not identify or accumulate data for group practices, we concentrated on providers in a clinic setting who served many Medicaid recipients. We selected 2 provider groups which were among the 10 highest in dollar volume of Ohio Medicaid payments in calendar year 1976 and which had not previously been investigated.

The Bureau does not have any specific criteria or standards for selecting and reviewing cases for potential abuse. Using detailed reports on the selected providers' paid claims, we set our own criteria for selecting cases to be reviewed. SUR reports list the areas in which a given provider exceeds the peer average. Of the two provider groups we selected, one had a very high number of exceptions; the other had very few.

We identified potentially abusive patterns in the reports the Bureau receives; some highlighted by provider group exceptions and others based on our own judgment. We selected

a sample of recipient cases which fit the patterns and visited the clinics to review the medical files on the cases in question.

We developed the following five areas of potential abuse of physician services.

(1) Several visits by one recipient to a clinic within a short span of time associated with what appeared to be a minor ailment. For example, one case involved a woman about 30 years old who visited the provider's office 72 times in 57 weeks. She complained generally of headaches, colds, backaches, nausea, and "pain all over." We considered such cases to be potentially excessive visits.

(2) More than one family member visiting the clinic on the same day, often receiving similar or identical treatment. In one of our cases, a mother and her three children all visited the provider's office on the same day. The mother was diagnosed as having iron deficiency anemia and was given some lab tests. All three children were diagnosed as having upper respiratory infection and their treatment was coded as a "brief service." One child was given a complete blood count. In another case, a mother and her child visited the clinic 7 times in a 6-month period. They always came on the same day and treatment was always coded as an office visit.

(3) Recipients being issued the same prescription for a prolonged period without regular visits to the clinic. In one of our cases, a recipient filled and refilled a prescription for antiobiotics 19 times over a period of nearly a year.

(4) Instances where a series of five or more laboratory tests or radiological procedures were performed on a recipient during one office visit. For example, a recipient was given 13 blood tests when she visited the clinic complaining of a cold. In another case, a recipient was given 18 laboratory tests during 1 office visit.

(5) Instances where the treatment given appeared to be unrelated to the stated diagnosis. Examples of these conflicts were a foot X-ray given in conjunction with a diagnosis of hypertension and a pregnancy test coded as the treatment for bronchitis. As discussed on page 91, these types were normally explained by the clinic's billing process.

We verified that prescriptions and pathology and radiology procedures were given. Without criteria and standards we could not determine that misuse or abuse of the Medicaid program had occurred. Conflicts between treatments and diagnoses on the State reports were explained by the clinic's billing procedures. The clinic used a billing cycle and often included several office visits and treatments for a recipient on one invoice submitted to the State agency. Since the invoice form has space for only one diagnosis code, the clinic lists only the primary diagnosis. In many cases, treatments are given during a billing cycle for conditions unrelated to the primary diagnosis.

The physicians agreed that some recipients may be making excessive visits or family visits to the clinics, but said they were obligated to see the recipients when they request to be seen. Without a clear definition of how often or for what reasons it is proper for a Medicaid recipient to visit a physician, we could not conclude that numerous or family visits actually represented abuse of the program.

Dentists

We audited two groups of dental providers from the 10 groups or clinics which had the highest volume of Ohio Medicaid dental payments in 1976. The Medicaid practices of these two groups were not under some type of investigation.

Provider Summary Profile reports indicated that one dental group exceeded the Medicaid norms in several categories. The second group had only one exception in the category of dollars paid which is characteristic of all large volume group providers. We spoke with a State dental consultant who helped us to detect potentially abusive patterns of treatment. Also, the State agency's provider handbook describes limitations on certain dental services such as X-rays and number of fillings per tooth. Using the above indicators, we chose a sample of 98 cases which appeared to have excessive or improper treatment patterns. We also selected 30 cases that appeared to have normal dental services.

We visited the two dental clinics and examined the records for our sample cases. We also discussed Medicaid practice with the providers. The types of cases we selected fell into one of the following categories:

(1) Cases involving 10 or more fillings during 1 appointment which might indicate excessive utilization. A few of the cases showed as many as 20 or even 30 fillings on the same date.

(2) Instances where two invoices apparently had been submitted for the same recipient for identical treatment. For example, State agency records showed invoices were submitted for services (teeth cleaning and X-rays) given on February 5 and 26 to the same recipient. In another case, State records showed that a recipient received an initial exam complete with X-rays 2 weeks in a row.

(3) Cases where State records showed that incompatible dental treatments were given. These cases showed such treatments as extracting a tooth and then filling the same tooth at a later date. We selected a few cases in which the recipient received partial dentures and also had other work done in the same area of the mouth.

(4) Cases where the combination of dental services rendered exceeded limits set forth in the State agency's Provider Handbook. The State allows only $18.00 of fillings on any one tooth, only one full-mouth or panoramic X-ray every 3 years, an initial examination once a year with a 6-month check-up, and all combinations of dental X-rays may not exceed $15.00 per year. Some recipients received $24.00 in fillings on one tooth, many providers billed the State for a panoramic X-ray at $15.00 and also for a bitewing X-ray at an additional $8.00 in the same year, and some recipients were given an initial examination twice in the same year.

(5) Cases which appeared to represent normal dental services. For example, some cases in this category involved (1) an initial examination with X-rays and a 6-month check-up with some fillings, (2) taking impressions and/or extracting teeth for dentures, and (3) crowns and treatment for decayed teeth.

Our review of dental records at the clinics verified that an excessive number of fillings were given at one sitting for the cases in this category. The providers said they filled all the teeth at once because they could not be sure the recipient would return for a second appointment. Although the State agency's dental consultant frowned on this practice, he would not take the position that it was abusive.

For cases involving possible duplicate procedures or billings we generally could not find a record of both treatments at the clinic. The providers explained these cases as clerical errors. For example, in one case the clinic mistakenly billed a dental examination twice, rather than for fillings which had been given during the second appointment. In another case, the clinic mistakely sent the same invoice to the State twice.

Some of the conflicting treatments were also explained as clerical errors, such as the wrong tooth number being recorded in the chart or on the invoice. For the cases in which it appeared dental work was done in portions of the mouth where partial dentures were, the clinic charts revealed that, in all cases, the work was done on teeth other than those replaced by dentures. Our sample cases of normal dental services were verified by the providers' files.

Clinic files supported the fact that dental services which exceeded State limitations had been rendered. Most of these cases exceeded the $15.00 per-patient-per-year limit on X-rays. Both provider groups had been under the impression that exceeding this limit was acceptable, since they had no difficulty getting paid. The providers had not interpreted the handbook's statement of the limitation as strictly as the State. The $15 limitation statement appears twice under specific radiodontics codes, and the providers thought the limit applied only to the specific codes. We agree that the handbook is misleading. The limits should be more clearly worded and positioned more effectively in the text.

Concerned that misinterpretation of the X-ray limitation may have been a widespread problem, we made a computer analysis of State agency data to determine the number of recipients and the dollar amount involved in exceeding two State agency limits: (1) $15.00 per-recipient-per-year for all combinations of X-rays and (2) one panoramic X-ray per recipient every 3 years. We analyzed a 3-year period ending December 31, 1976, and identified the following overpayments.

	Year	Amount
Exceeding $15.00 limit	1974	$111,637
	1975	136,110
	1976	78,438
		$326,185
Panoramic X-ray excess		196,560
Total		$552,745

Although the State has limited X-ray services since 1972, edits in the claims processing system to identify overcharging for X-rays were not used until early 1977.

HEW REVIEW OF FRAUD AND ABUSE

In the fall of 1976 a team of HEW Medicaid examiners reviewed services provided by 50 physicians, 51 pharmacies, and 11 clinical laboratories in Ohio to determine if the billed services were in fact done. Most of the providers reviewed were randomly selected from high-volume providers. The HEW examiners (1) filmed the medical records or prescriptions of 25 selected claims for each provider and (2) interviewed each provider regarding the type of practice maintained and the usual and customary charges for services. Upon completion of the field review, an indepth analysis was made to determine if the claims were properly submitted. The HEW examination developed these findings:

--For physicians, 95 discrepancies were detected for physicians selected on a random basis; 122 discrepancies were detected for physicians selected because they exceeded selected norms; and the most common finding was lack of documentation supporting claims.

--For pharmacies, 405 discrepancies were detected and the most common findings were lack of documentation supporting claims and claiming an amount which exceeded that charged to non-Medicaid patients.

--For laboratories, 57 discrepancies were detected and the most common finding was lack of documentation supporting claims.

HEW examiners concluded that 11 providers' records showed major irregularities where a high incidence of potential abuse or a number of more serious types of violations existed. They also identified 66 providers whose records showed less significant problems, and 33 with minimal or no irregularities. However, all of the discrepancies were identified as "potential abuse," and the most common finding was lack of documentation supporting claims. No fraud, abuse, or misuse was proven.

ALTERNATIVE ANALYSIS TO MONITOR AMBULATORY SERVICES

As stated in previous sections, one of the problems that the Bureau has is the lack of criteria on abuse and misuse. We reviewed an alternative system to determine if the principles of this system could be successfully applied to the State Medicaid program and concluded that it could be effectively used by the State and could provide some of the needed criteria to judge both quality of care and potential abuse or misuse of medical services.

Physician Ambulatory Care Evaluation

The Physician Ambulatory Care Evaluation (PACE) program was conceived by the Utah Professional Standards Review Organization in 1971. PACE is comprised of both a computerized system for initial processing and screening of medical care claim forms and a professional review component. Both elements analyze physician practice patterns in terms of peer expectations and comparative performance.

PACE centers on the professional evaluation of the appropriateness and necessity of ambulatory care as billed to Medicaid. The screening guidelines are applied just prior to payment, that is, after eligibility and benefit coverage have been determined. PACE uses profiles of services received by each patient and the practice of each provider over a period of time. If some aspect of a patient's care deviates from preestablished screening parameters, it is reported for scrutiny by reviewers.

PACE uses certain criteria for diagnoses and procedures commonly used in providing medical services to Medicaid recipients and is designed to review medical care based almost entirely on the information normally reported on claim forms. For example, if a recipient has diabetes and this diagnosis code is properly listed as the primary illness on the claim

form, it would be expected that the recipient would receive at least 1 urinalysis per year, no more than 2 blood/sugar analyses within a 180-day period, and no more than 4 office visits within a 180-day period. Not meeting these criteria would cause a claim with a diabetes diagnosis to be reported for scrutiny by reviewers.

To demonstrate how a system such as PACE might work in Ohio, we selected 12 diagnosis or procedure codes and applied the related criteria for each of these codes to the Ohio paid claims history file. The selected diagnoses or procedures and related criteria are as follows.

Situation tested	Criteria
Diabetes mellitus	At least 1 urinalysis per year, not more than 2 blood/sugar analyses within a 180-day period, and no more than 4 office visits for diabetes within a 180-day period.
Infectious mononucleosis	Each episode requires a complete blood count.
Vaginitis	Requires a wet mount smear or culture to be taken within 180 days of first office visit or by the second visit.
Tonsillectomy	Required 3 occurrences of acute tonsillitis or tonsil hypertrophy in a 180-day period.
Nausea	Requires X-rays or lab tests to be done when this diagnosis is used to determine cause.
Office visits	Flag more than 4 brief office visits during a 60-day period.
Comprehensive exam	Flag more than one comprehensive exam per year per patient.
Use of oral contraceptives and the diagnosis "Depression"	Flag any use of oral contraceptives when the patient has depression diagnosis.

Situation tested	Criteria
Use of Valium during pregnancy	Flag the use of Valium during 9 months prior to delivery.
Use of B-12 injection	Provides for use of B-12 injections in only certain situations such as celiac disease, pernicious anemia, and diverticulosis of small bowel.
Use of complete blood count	Flag more than two complete blood count tests a year, unless several diagnoses were given.
Urinalysis	Flag more than one urinalysis per quarter for other than several diagnoses.

To apply these criteria, we randomly selected 3 percent of the Medicaid recipients who received services in calendar years 1975 and 1976. For all instances where the 12 selected diagnosis or procedure codes occurred, we verified whether or not the related criteria was met. A summary of this analysis follows.

Diagnosis or procedure	Cases in sample	Cases meeting criteria	Cases failing PACE criteria	Percent failed
Diabetes mellitus	285	33	252	88
Infectious mononucleosis	26	6	20	77
Vaginitis	832	88	744	89
Tonsillectomy	1,590	1,589	1	0
Nausea	90	58	32	36
Office visits	51,804	51,085	719	1
Comprehensive exam	25,902	24,160	1,742	7

Diagnosis or procedure	Cases in sample	Cases meeting criteria	Cases failing PACE criteria	Percent failed
Use of oral contraceptives	1,378	1,218	1,742	7
Use of Valium	605	576	29	5
Use of B-12 injection	52	2	50	96
Use of complete blood count	147	46	101	69
Urinalysis	1,708	29	1,679	98

This analysis showed quite a few instances where actual services provided varied from the PACE criteria. This does not mean that these services were wrongly provided, but it indicates that the use of such criteria would lead the State to question a significant number of services provided to Ohio Medicaid recipients. Also, if such questions were raised before these services were paid, a significant savings might accrue to the program through the prevention of payments for misuse of services.

We discussed the potential of Ohio developing a program similar to PACE with Bureau officials who said a PACE-type program would certainly provide excellent standards to monitor the quality of care, as well as to identify abuse and misuse. The officials pointed out that in order for PACE to be used effectively, they would need to hire a full-time physician to act as a medical advisor. Also, they doubted if the providers would accept the program. Discussions with officials of the Ohio State Medical Association and the Ohio Osteopathic Association indicated that the professional provider associations objected to using such criteria. Each association complained that the provider would be locked in to the criteria and thus could not exercise professional judgment. One of the officials labeled this "check list" medicine which could be handled by a technician, not a highly trained doctor.

These fears might have some merit but it should be reiterated that under PACE, provider groups are heavily involved in the development of the criteria. Also, since the system is designed to assure the quality of care as well as preventing potential overuse, it would appear that providers should be willing to participate in such a program.

OHIO EXPLANATION OF MEDICAL BENEFITS

One of the Federal requirements which must be met before a State can receive 75-percent Federal reimbursement for Medicaid claims processing costs is that an explanation of medical benefits (EOMB) must be mailed monthly to at least a sample of recipients. An EOMB is a notice from the State to the recipient that includes the following information about Medicaid claims paid on their behalf.

--When a service was provided.

--What type of service was provided.

--Who received the service.

--Who provided the service.

--How much was paid.

An EOMB program provides

--more favorable Federal matching funds to meet the notification provision of Public Law 92-603, sec. 235(3);

--a means of educating recipients;

--a useful tool for utilization review; and

--a means of error detection.

The State began mailing EOMBs on a sample basis in March 1976, at which time about 6,000 recipients were reached. In January 1977 the program was extended to cover all recipients. About 600,000 EOMBs are now mailed each month, of which about 12,000 are returned by recipients with questions. Although the majority of the returned EOMBs are easily resolved, the Bureau staff maintains a card file on legitimate inquiries, particularly those that indicate potential fraud or abuse. Some of these have resulted in audits being initiated. For example, three dental audits resulted from complaints listed on EOMBs that billed services were not received. The Bureau also performed a pharmacy audit based, in part, on information obtained from EOMBs.

We believe the EOMB system is an effective way for the Bureau to monitor the medical services provided under Medicaid and that use of this system should be encouraged.

CK-IN POLICY

Bureau staff are participating in the development of a new policy to control overuse by selectively restricting recipients who overuse services to one physician and one pharmacy of their choice for a 12-month period. The purpose of this restriction is to evaluate whether the Bureau can effectively curb recipient overuse or misuse and identify abuse. Additionally, the policy may

--educate recipients about the appropriate use of health care services,

--improve quality of medical care through the development of a more stable patient-physician-pharmacist relationship,

--provide continuity of medical care by placing the responsibility for the planning of care and treatment under one managing physician, and

--improve utilization patterns to control Medicaid expenditures.

The Bureau feels that this restriction will help to comply with Federal regulations that require a post-payment review process that identifies exceptions in order to rectify misuse practices of recipients, providers, and institutions. The State agency indicated in its comments on our report that it planned to implement a lock-in program by the end of 1978.

REVISED MEDICAL ASSISTANCE CARD

On September 1, 1977, Ohio welfare recipients were issued a revised medical assistance identification card. The purpose of the new card is to provide a means of controlling overuse of medical services. The front of the new card contains the age of each recipient to assist each provider to determine with more assurance whether the person seeking treatment is an eligible recipient for the services to be provided and to restrict the borrowing of identification cards.

The reverse side of the card has been redesigned to provide an area in which a pharmacy/physician can record all visits made by recipients. The Bureau feels that proper completion of this portion of the card will (1) assist in controlling excessive use by minimizing such abuses as "doctor shopping" and borrowing of cards and (2) alert physicians and pharmacies that the patient has been, or is being treated by another physician, and that services provided are not in excess of those allowed under State policy.

CONCLUSIONS

Although the Bureau has identified many potential overuse practices, the lack of firm criteria and standards had limited its success in sustaining findings of abuse and misuse. We did not identify any fraudulent activities, but we did find many cases of potential abuse or misuse. An HEW study was unsuccessful in its attempt to identify fraud.

The State produces many reports for use by the Bureau which are sparingly, if ever used, or which include unnecessary data. We believe the Bureau should review all the reports received so that it could recommend eliminating unneeded ones and modifying reports to make them more useful.

We applied a technique designed by Utah's PSRO for prepayment utilization review of ambulatory services that we believe could be beneficially adopted by Ohio's Medicaid program. We also believe that several new methods used or planned by the State should help control the use of Medicaid services.

RECOMMENDATIONS

To provide the Bureau with criteria and standards in its review of potential misuse of Medicaid services, we recommend that Ohio develop a system similar to Utah's PACE program. Such a system would not only help in monitoring use, but it would also help in evaluating the quality of care.

With respect to the data base supporting the SUR subsystem, we recommend that the State designate the Bureau to provide the necessary leadership to improve the data base by assuring that billing procedures result in correct diagnoses and procedure codes. Also, we recommend that the State require the Bureau to review the many reports generated by

the SUR subsystem to identify unneeded reports and to prevent the processing of unneeded and irrelevant information.

AGENCY COMMENTS

The State Medicaid agency agreed with our conclusions and recommendations. However, the State's comments did not cite actions it was taking to implement the recommendations except that it would study the possibility of using criteria like those in PACE.

Regarding development of a system similar to PACE, the State said that because PACE is primarily a prepayment review system requiring considerable administrative support, the State agency considered it unrealistic for a large State such as Ohio. The State agreed that PSROs would have to be heavily involved in a program like PACE and that the medical profession's opposition to any "checklist medicine" complaints about a PACE-like system would have to be overcome.

The PSRO law calls for PSROs to eventually review the necessity for and quality of Medicaid ambulatory services. Utah's PACE is the system used by that State's PSRO to meet this requirement. We believe that by working with the Ohio PSROs, the State could participate in developing a PACE-like system. Since the federally funded PSROs would be doing the actual utilization review with information provided by the State computer system, the State would incur relatively little additional administrative cost. Also, because the medical profession is heavily involved in the PSRO program, it should be easier to overcome any opposition to a PACE-like system.

The State also posed the question, if the PACE concept has such validity, why has HEW not developed it on a national level and shared it with the States. HEW has, and will, financially assist in the costs of developing PACE-like systems. Also, those systems that have been developed are available for State use. However, normally, a State would be expected to use PSROs for the actual review function because of the need for medical professionals.

The State agency also commented that it has made substantial progress, since our fieldwork, in investigating and referring for prosecution Medicaid fraud cases. The State said it believes enactment by the Congress of Public Law 95-142, the Medicare and Medicaid Anti-Fraud and Abuse

Act, will greatly assist it in controlling the Medicaid program. In conjunction with Public Law 95-142, the State gave its Attorney General authority to pursue issues of provider fraud and abuse. The State also established a penalty of triple damages when provider fraud is proven. As of August 1978, the State agency had referred 62 provider cases to the Attorney General, but many of these cases appeared to relate more to abuse than to fraud.

CHAPTER 10

BETTER USE OF CONTROL MECHANISMS CAN IMPROVE INSTITUTIONAL MEDICAID SERVICES

Federal law requires States to have programs to control the utilization of institutional services under Medicaid. Requirements for these programs concentrate on the use of qualified health professionals to assure the necessity for institutionalization and the provision of quality health care.

Ohio institutions use (1) in-house committees of physicians and other professionals, (2) a State agency committee, or (3) the recently established Professional Standards Review Organizations. The State agency has also used independent contractors to meet some of the Federal control requirements. In all cases, utilization control programs are the State agency's primary source of information regarding the institutional health care needs of its Medicaid population and the integrity of services provided.

Portions of Ohio's institutional control programs did not meet Federal requirements. Even when Ohio was in technical compliance with regulations, it made little use of the information generated. Health care evaluations were not used to determine the appropriateness of Medicaid payments to mental hospitals and long-term care institutions. Utilization control did not include adequate mechanisms to relocate recipients who were in institutions unnecessarily. The effect of utilization control on the quality of institutional services rendered was relatively unknown.

UTILIZATION CONTROL OVER HOSPITAL SERVICES

In fiscal year 1977, Ohio spent about $190 million (34 percent of its total Medicaid expenditures) for inpatient hospital services for 140,699 Medicaid recipients.

The Social Security Act describes two types of control systems to be used in hospitals--hospital-based utilization review committees described under title XVIII (Medicare), and PSROs under title XI. Almost since the inception of

Medicaid, States have been required to use the title XVIII committees as part of a statewide utilization control program. The Social Security Amendments of 1972 (Public Law 92-603) mandated the use of PSROs once they were established. PSRO review systems are being implemented first in hospitals, since the amount of Medicare and Medicaid expenditures is largest for this category of service. PSROs will expand to mental hospitals, long-term care facilities, and eventually ambulatory services. As review programs are implemented, PSROs will take over the State's responsibility for determining medical necessity and quality.

Both of these utilization control systems reflect congressional conviction that health professionals are the most appropriate individuals to evaluate the necessity and quality of health care services. Also, both systems rely on peer review at the local level as being the soundest approach to assuring the appropriate use of medical resources and facilities.

In chapter 12, we discuss the fact that many recipients who could be adequately cared for in skilled nursing facilities are being kept in hospitals because Ohio's payment rates for SNF services are too low to cover the costs associated with recipients needing high levels of skilled care. Obviously, PSROs and title XVIII committees are certifying continued hospital stays for recipients who should be transferred to SNFs because the hospitals continue to be paid for these recipients. This occurs because, if a hospital cannot place a recipient in a SNF, it is medically necessary to permit the recipient to remain in a hospital where he or she can receive skilled care. In chapter 12, we also make recommendations designed to increase the availability of SNF services. Increased availability of these services would help eliminate the need for PSROs and title XVIII committees to certify as medically necessary continued hospital stays for recipients who could adequately be served in lower cost SNFs.

Title XVIII committees

Federal Medicaid regulations require that hospitals not covered by PSROs have utilization review committees of two or more physicians and a written review plan. These committees normally are the same ones established to meet the requirements of title XVIII. Each committee's written plan should establish procedures for timely review of the necessity for

hospital admissions and extended duration stays. Due to opposition from the American Medical Association, HEW has delayed enforcement of the admission review portion of the regulations. HEW is revising the regulations to incorporate the Association's suggestions into provisions which will remain consistent with statutory requirements.

The State agency relies on the title XVIII committees to approve hospital invoices submitted under the Medicaid program. In addition to the above mentioned Federal requirements, Ohio has asked title XVIII committees to monitor some special services. The State agency has instructed the hospital committees to deny routine weekend admissions and services, admissions for diagnosis and evaluation only, hospital admissions for more than 1 day prior to surgery, and hospital stays due to inability to secure placement in an alternate type of facility unless it was absolutely necessary for the recipient to be hospitalized in these situations.

The Ohio Department of Health evaluates the title XVIII committees for compliance with HEW standards during its annual hospital certification surveys. The Administrator of the Health Department's hospital certification unit said he enforces all segments of Federal utilization control regulations except the admission review requirement. In practice, the make up of hospital utilization review committees, their methods, and the criteria they use vary across the State. Some hospitals do not make any admission reviews.

The State agency only spot checks the title XVIII committees and does not communicate with the Health Department regarding its certification surveys. The State agency, therefore, is not fully familar with the title XVIII committees' various review practices. Also, the agency has no assurance that the committees are enforcing special State restrictions. Improvements or deficiencies noted in hospital health care delivery, as a result of title XVIII committee efforts, are not incorporated into the statewide management of Medicaid services.

PSRO review programs

Public Law 92-603 required the Secretary of Health, Education, and Welfare, to establish and support a network of nonprofit groups of local physicians called PSROs. Congressional intent behind the PSRO legislation was twofold:

to ensure that health care provided under the Social Security Act is of high quality and to slow down the rapidly rising program costs for such care. As such, PSROs must determine whether health care services provided to Medicare, Medicaid, and Maternal and Child Health program recipients are medically necessary, whether they meet professionally recognized standards, and whether the level of care provided is the most economical and consistent with the patients' medical needs.

The Secretary of HEW has designated 13 PSRO areas across Ohio. As of October 1977 six PSROs had achieved conditional status, the developmental stage in which they put their hospital review programs into operation and, as they are found competent, assume binding authority over Medicaid payments. Six of the remaining seven PSRO areas were in the planning stage and one had not yet been organized. The conditional PSRO areas cover the State's major cities. Conditional PSROs began implementing their review programs in Ohio's hospitals early in 1976. In November 1977, PSROs had review responsibility and binding authority over payments in 108 of Ohio's 205 hospitals. These 108 facilities have 61 percent of the total beds certified for Medicaid recipients.

The conditional PSROs have delegated their review responsibilities to the title XVIII committees in all but 17 of the 108 facilities. We visited both delegated and nondelegated hospitals and determined that, in both cases, PSROs appeared to be adhering to HEW guidelines. Because the PSROs had recently began hospital reviews and were not operating in all regions of the State, we did not attempt to evaluate their review systems in terms of cost containment or impact on quality of care.

Five conditionally designated PSRO contracts for one year of hospital review were awarded by HEW in 1976. The contracts averaged about $340,000 and totaled about $1.7 million. These cost figures do not include the cost of the review process within delegated hospitals. HEW guidelines published in March 1977 established procedures for Federal reimbursement to delegated hospitals at a fixed-cost-per-admission. The States do not contribute money to PSROs.

HEW encourages State agencies to negotiate formal agreements with and to monitor PSROs. The Government will share in State expenditures for monitoring activities, as long as it does not duplicate the PSRO review. HEW must consider State recommendations before deciding to convert a PSRO to

a fully operational status, so State monitoring is important, especially during its early, development periods.

The State agency has been in contact with PSROs since their organization, but has relied on HEW and the statewide PSRO support center in Columbus (which is funded by HEW to assist PSROs in establishing their programs in Ohio) to organize and develop the review groups. When PSROs began implementing their review programs in hospitals, the State agency negotiated agreements with PSROs which outlined the responsibilities of each party and agreed to abide by PSRO determinations regarding Medicaid services. During the first year of PSRO hospital review, the State agency had one staff member assigned to the PSRO program who was only able to devote 10 percent of her time to establishing working relationships with conditional PSROs and coordinating PSRO activities within the State agency. She had not analyzed or evaluated any PSRO review programs.

Coordination among units within the State agency whose work interfaces with PSROs needs improvement. Some State agency units do not have a good understanding of what PSROs are and what they do. For example, a PSRO hospital could submit claims without PSRO approval because invoice processing personnel did not screen claims to determine if they had PSRO approval. Therefore, the hospital had to make sure claims had approval.

A great deal of confusion has surrounded the length of hospital stay certified by the PSRO on the hospital invoice. The PSRO authorizes the number of days in the hospital based on statistical norms for the recipient's diagnosis. If the recipient does not remain in the hospital for the entire time authorized, the number of days authorized by the PSRO and the number of days billed does not agree. This confusion had caused long delays in payment of hospital invoices. The State agency solved this problem by asking PSROs to authorize the same number of days actually billed, or to provide formal notification that the authorized period may be longer than the actual hospital stay.

PSRO review programs are operating in over half of the hospitals in Ohio, and State agency personnel are becoming concerned about the amount of control PSROs have over payment of hospital claims. The State agency was working on a plan to monitor PSROs by comparing length of stay in PSRO hospitals to statewide data on Medicaid recipients and to regional

norms developed by the Commission on Professional and Hospital Activities. Ohio's monitoring plan is being patterned after California's plan which has HEW-approval.

Mental hospitals

Ohio's Medicaid program covers recipients 65 years of age or older and children under age 21 who are patients in hospitals for mental diseases. The Ohio Department of Mental Health and Mental Retardation pays the State's share of Medicaid costs for inpatients of mental hospitals, while the State agency sets policy and reimbursement rates. Mental hospitals serving children under age 21 must be accredited by the Joint Commission on Accreditation of Hospitals. To serve persons age 65 and older, the hospital must be accredited and be certified to participate in the Medicare program. Fifteen public mental hospitals are participating in Ohio's Medicaid program.

Federal requirements for utilization control of mental hospital services parallel those for general hospitals. Mental hospitals must establish title XVIII committees to perform the review functions discussed earlier. Ohio PSROs were not yet ready to review mental hospitals. To further guard against needless prolonged institutionalization, mental hospitals are to see that each Medicaid recipient has a written plan of treatment which is regularly reviewed and updated by a physician. The hospital is also responsible for obtaining written physician certification and periodic recertification of the need for institutionalization.

In response to HEW regulations and in anticipation of PSROs assuming review responsibility for mental hospitals, the Ohio Department of Mental Health and Mental Retardation has designed a mental health peer review program which fulfills the above requirements. This program has been operational in all of the State's public mental hospitals since the fall of 1976. Peer review data, including medical care evaluation studies, were retained by the review committee in the hospital and were not monitored, except for annual inspection by a medical review team (described later in this chapter). The State agency, therefore, could not continually evaluate the effectiveness of the mental health peer review program with regard to the appropriateness or quality of institutional care provided Medicaid recipients.

Mental hospitals have had difficulty finding suitable alternatives to institutionalization when the title XVIII committee determines a recipient's continued stay is not necessary. We could not obtain information on the number of successful outplacements attributable to the peer review program, but we noted mental hospitals did not routinely refer recipients to the county welfare departments for discharge planning. The State agency did not use peer review data to verify the appropriateness of Medicaid payments to mental hospitals.

UTILIZATION CONTROL OVER LONG-TERM CARE INSTITUTIONS

Thirty-three percent ($182 million from July 1976 to June 1977) of Ohio's Medicaid dollars supports approximately 45,000 recipients of SNF and ICF services. Concern over the quality of care given Medicaid recipients and the medical necessity for long-term institutionalization has prompted the Congress to mandate utilization controls over these services. The principle behind this utilization control legislation is that physicians and other qualified health professionals should supervise the institutional placement and regular care of these recipients.

Since at the time of our fieldwork no Ohio PSROs had assumed responsibility for long-term care facilities, the State was required to use title XVIII committees to review the admission and continued stay of each Medicaid recipient receiving skilled nursing care and to evaluate skilled care. The States may establish title XVIII committees to review intermediate-level care or the State agencies may do these reviews. A long-term care facility must obtain a physician's certification and periodic recertification of the need for institutionalization for each Medicaid recipient. Each recipient must have a written plan of care which is periodically reviewed and updated by a physician. Recipients receiving skilled care must have written discharge plans.

The Secretary of HEW may waive the requirement for utilization review committees for SNFs if the State agency demonstrates to his satisfaction that it has utilization review procedures which are more effective than those required by the Social Security Act. Accordingly, the State agency in Ohio submitted an alternate system for a State committee to review the long-term care of all Medicaid recipients and a request for a waiver to HEW in January 1974. The State

agency said it was dissatisfied with the title XVIII committees' review decisions, suspecting the committees of certifying unnecessary skilled care.

An HEW regional team evaluated Ohio's alternate system in May 1976 and reported the deficiencies to the State agency. The HEW report discussed major problems such as lack of program goals, absence of a data collection system, failure to make admissions review and review of discharge plans, counties were improperly allowed to make nursing home payments without State agency approval, and lack of assurance that extended stay reviews were conducted. The State agency did not change its utilization review policies and, in January 1977, HEW denied Ohio's request for waiver of Federal requirements.

The effect of this denial was that unless the State agency altered its utilization review program to include local committee review of the need for skilled care, the State would be subject to reductions in Federal sharing in the costs of long-term skilled nursing care. Federal regulations permit the State agency to conduct utilization review of intermediate care cases; therefore, the State was not required to change policies covering these facilities or intermediate care recipients in SNFs.

The State agency was bringing its system for reviewing skilled nursing care into compliance with Federal regulations. SNFs, which also participate in Medicare, are now required to use title XVIII committees to review Medicaid recipients as well. SNFs which participate only in the Medicaid program must establish committees meeting title XVIII requirements. The Ohio Department of Health, which certifies long-term care facilities for Medicaid program participation, had advised the State agency that the Medicaid-only facilities would require several months to organize their utilization review committees.

Effectiveness of
long-term care review

We found that what HEW termed a lack of assurance that each recipient is reviewed in a timely manner translated into a failure to make a utilization review for all recipients and facilities. Some long-term care facilities had failed to fulfill their utilization review responsibilities. State agency personnel did not know how many Medicaid

recipients were affected by this breakdown in the utilization review process. The long-term care facilities have little incentive to comply with State requirements because utilization review was not a condition for payment of Medicaid invoices, and review results did not influence the payments a facility received.

Even when the utilization review process worked, Ohio made no use of the end results. The level of care authorized did not usually affect the amount of per diem paid to the long-term care facility because most beds were certified for both skilled and intermediate care and one payment rate applied, regardless of the level of care provided to a recipient. Although the county welfare departments received a copy of the level of care authorizations, the counties were rarely able to relocate recipients if the authorized level of care was incompatible with the current placement. Also, the State agency was not provided with the results of the retrospective medical care evaluation studies.

Ohio's new policy for review of skilled care may improve technical compliance with utilization control requirements on the part of SNFs. It did not appear, however, that the use of title XVIII committees would make the review process any more meaningful. The links with facility reimbursement and county welfare workers would still be missing, thus preventing the utilization control process from assuring proper use of the Medicaid funds and appropriate placement of recipients. The State agency had no plans to communicate with title XVIII committees regarding medical care evaluation studies or other activities which would help assess the quality of care provided to Medicaid recipients.

Utilization control project

Ohio has been contracting long-term care utilization reviews in eight southwestern counties to a private medical organization. The Director of this medical organization has been involved in long-term and geriatric care programs for several years. The contractor followed the basic procedure stipulated by the State agency and Federal regulations, but had injected some additional factors in an attempt to improve the process. The State agency had made no effort to evaluate the benefits of incorporating some of the contractor's methods into the statewide program.

We noted two significant additions in the contractor's program. The county welfare departments were actively involved in reviewing the need for institutionalization, and the medical care evaluation studies were conducted on an areawide basis. The goal of these studies is to help provide better quality long-term care.

The contractor had a county welfare worker visit each Medicaid recipient within 7 days after being admitted to a long-term care facility. During this visit, the county worker prepared a discharge plan assessment which was included in the recipient's written plan of care. If the county worker determines that the recipient had potential for discharge, the contractor referred the case to the county's social services division for formal discharge planning.

The contractor's medical care evaluation study committee completed 20 studies during the first 14 months of its contract, most covering all area facilities. A primary objective of the studies was to gather baseline data on the long-term care population. The contractor planned to use this data to establish better criteria and standards for the quality of long-term care. The State agency received copies of some of these studies, but made no use of the studies. The future of this project was uncertain due to the changes in State policy concerning review of skilled care.

Annual onsite reviews

In addition to the utilization review process, the State agency must provide for annual inspection and evaluation of each long-term care facility by an independent team of health care professionals. These onsite evaluations, termed medical reviews in SNFs and mental hospitals and independent professional reviews in ICFs, must include an appraisal of each Medicaid recipient in the facility. Specifically, the reviews should determine

--the adequacy of services available to meet recipients' needs as required by written plans of care;

--the adequacy, appropriateness, and quality of services actually rendered;

--the necessity and desirability of continued placement at the current level of care; and

--the feasibility and/or desirability of providing care at an alternate level or other type of facility.

Medical review teams must include a physician; independent professional review teams need only have access to a physician for consultation. To determine a facility's response to the review team recommendations, the State must provide an appropriate followup.

The State agency had contracts for annual reviews and followup functions with two private organizations. The State said contractors were used because the State could not provide sufficient professional staff to satisfy program requirements. The two contractors made the annual reviews during fiscal years 1976 and 1977. One contractor, who was responsible for 80 Ohio counties, had 12 review teams under personal service contracts. The second contractor covered eight counties with two full-time review teams and one part-time team, all of which worked directly for him.

The State agency has allowed the contractors to use their own criteria in determining the level of care required by each recipient. The contractors reported the results of their reviews differently. One contractor's recommendations related specifically to recipients; the other concentrates mainly on general recommendations encompassing the entire facility. They used different review forms and the amount of information reported differed significantly. The State agency did not control the scheduling of the onsite reviews and did not regularly monitor the contractors' activities. The State agency only used the review reports to complete its quarterly report to HEW on medical and independent professional reviews completed.

Due to a lack of State supervision, the contractors failed to review all facilities during a 12-month period. One of the contractors did not have sufficient funds to complete an initial review of every facility in fiscal year 1976. Neither the contractor nor the State agency could tell us how many facilities were missed. Rather than making sure that all initial reviews were completed, the State agency agreed that this contractor would only make followup reviews during the second half of fiscal year 1976. The other contractor had a smaller area, and did not have any difficulty visiting every facility. The contractors were able to complete reviews in all facilities during fiscal year 1977. HEW applied considerable pressure on the State agency to ensure the reviews were done before July 1, 1977.

The annual onsite reviews could improve the quality of services provided to Medicaid recipients. We sampled fiscal year 1976 medical and independent profession review reports and found the following improvements in institutional care were made as a result of these reviews.

A review team noted during its initial review of a home in Highland County that the home did not use consultants, such as podiatrists and physical therapists, to take care of special needs. During their followup review at this home, the team noted that consultants were available. An independent professional review team observed that an intermediate care facility in Morgan County did not have staff trained to plan activities for the patients. A followup visit showed that the facility had hired a full-time certified activities therapist. A medical review team discovered that a nursing home in Licking County was giving medications improperly due to poorly written charts and orders. The review team's followup visit confirmed that the facility had improved its records to avoid these mistakes. We also noted a number of instances where the review team helped the nursing facility to understand and comply with the State agency's paperwork requirements.

The State agency has instructed county welfare departments and district offices to assure that medical and independent professional review recommendations on recipient placement are followed and counties must report why the recommendations were not implemented. We discussed the impact of the annual reviews on placement with county and district personnel. The district medical supervisors said they monitor county welfare department actions on review recommendations and help with relocation problems. They indicated that most recommended changes in level of care were accomplished on paper without actually moving the recipients, due to Ohio's certification of SNFs to provide intermediate care also. County personnel have had some success moving recipients between SNFs and ICFs. However, recommendations for relocating recipients to a noninstitutional setting were rarely implemented because county workers cannot find suitable alternatives to institutional care and recipients or their families are unwilling to make the move.

CONCLUSIONS

Utilization review programs for institutional services are the State's major source of information regarding the necessity for institutionalization of Medicaid recipients, the appropriateness of the level of care they receive, and the quality of that care. However, Ohio's program for utilization review of institutional services appeared to be designed primarily to prevent a reduction in Federal sharing in the costs of long-term care required by section 1903(g) of the Social Security Act rather than truly controlling the use of institutional services and assuring that these services provide quality care to recipients. Specifically, we found:

--No link between the utilization review program and the claims payment process.

--The State agency did not communicate effectively with the local committees which conduct utilization reviews.

--The State agency relied almost exclusively on the State Health Department to assure that the local review committees met applicable Federal and State requirements but did not communicate with the Health Department.

--The State agency made virtually no use of medical care evaluation studies which assess quality of care.

--The State agency had allowed PSROs to assume binding review authority for Medicaid services provided in half of the State's hospitals without evaluating PSRO standards or review methods.

--Review methods for skilled nursing facilities did not conform with Federal requirements.

--Level of care determinations often had no affect on the placement of Medicaid recipients.

Also, as discussed in chapter 12, an improved utilization review program and a change in the methods of paying for skilled nursing care and certifying long-term care facilities could reduce Medicaid costs by millions of dollars.

We believe utilization control programs offer State Medicaid administrators the opportunity to gain useful

insight into the Medicaid institutional services program. Persons responsible for planning health care programs, structuring Medicaid benefits, formulating State policies, and budgeting Medicaid could benefit from the professional input of utilization reviewers.

RECOMMENDATIONS

We recommend that the State agency:

--Improve communications with all of the various groups conducting utilization review and the State Departments of Health and Mental Health and Mental Retardation regarding their utilization review functions.

--Ensure that links are established between the utilization review and claims payment system so that only approved care at the necessary level is paid for.

--Obtain the medical care evaluation studies prepared by the various utilization reviewers and use them to improve quality of care.

--Become more involved in understanding and evaluating PSRO programs.

--Ensure that all required onsite reviews are conducted, establish review schedules for its contractors, and monitor their completion.

--Require its onsite review contractors to uniformly report the results of their reviews so that State agency personnel can more easily analyze the results of these reviews and develop overall statistics.

The State agency should also coordinate its utilization review programs with health planning activities in the State so that health construction can be tailored to meet patient level of care needs. The county welfare departments should also be more closely integrated into the utilization review program to help correct problems in transferring Medicaid recipients among the various levels of care.

AGENCY COMMENTS

The State Medicaid agency said that it agreed with our recommendations and would institute those corrective

actions it has the legal authority to do. The State said it now regularly monitors its contractors performing utilization control activities in nursing homes.

The State said that the cumulative effect of State and Federal provisions regarding medical eligibility for nursing home care results in the various utilization control programs' findings to be almost meaningless and that the State cannot pay only for the necessary level of care. Thus, the State agency agrees with our conclusions. These problems are discussed in more detail in chapter 12.

The State said that it has assigned additional staff to PSRO activities, that its monitoring plan for PSRO hospital review was approved by HEW in July 1978, and that its monitoring plan for PSRO long-term care review was being revised based on HEW comments. PSRO review of long-term care was begun in one area in May 1978 and was scheduled to begin in another area in September 1978.

The State agency also said it has established links between the utilization review and claims payment systems by (1) screening hospital claims to ensure proper certification of medical necessity is present before payment is made and (2) requiring preadmission review of necessity of nursing home services before payment is made. The State is revising its policy to require prior authorization of lengths of stay required because of difficulties in transfering patients to another level of care.

CHAPTER 11

IMPROVEMENTS COULD INCREASE RECOVERY OF FUNDS FROM THIRD PARTIES

Medicaid law and regulations require that States make all reasonable efforts to determine the liability of and collect from third parties (health and accident insurance, Medicare, etc.) for costs of medical care and services provided to Medicaid recipients. However, Ohio had no organized program to collect from third parties until 1976--some 10 years after the Medicaid program began. Before 1976 Ohio relied primarily on providers to collect reimbursements from third-party sources before billing Medicaid. Many providers did and continue to follow this practice, especially regarding Medicare. Because the State believed providers were collecting only a small portion of available third-party moneys, Ohio established a third-party resources unit in October 1976 to recover from third parties after providers were paid. However, weaknesses in the unit's management and direction resulted in limited progress.

COLLECTION EFFORTS LACKED MANAGEMENT DIRECTION

As of June 1977 written procedures and instructions to the unit's personnel were nonexistent. Work was assigned verbally and without complete explanation as to what the employee was to do or what was to be done with the employee's product. As a result, unit employees have had difficulty performing tasks efficiently and economically.

Also, management did not review or evaluate the staff's work or assure that the staff concentrated on the most productive recovery areas. As a result, much of the staff's time was spent trying to recover funds in areas where the potential payback was low. For example, one employee spent 8 months investigating potential fraud recoveries, but no money was collected. Another employee spent 6 months developing cases in which Medicaid providers may have been paid by both Medicaid and Ohio Worker's Compensation. Again, nothing was recovered. A third person spent 4 months attempting to encourage Medicaid recipients to become eligible for Supplemental Security Income benefits. This effort, if successful, will result in the State saving only Aid to Families with Dependent Children, not Medicaid, moneys.

During our review, the State took steps to improve its third-party recovery effort. Detailed guidance to the staff was being drafted. The unit's operations were being computerized to inform management on the success of each recovery effort.

Also, recovery efforts were concentrated in (1) health insurance companies, such as Blue Cross/Blue Shield and (2) tort actions in favor of Medicaid recipients. As of June 30, 1977--after 8 months of operation--the unit had recovered $525,000--mostly from tort actions--representing a return of 3.8 times its operating budget of $138,000 for the period.

BETTER COORDINATION NEEDED WITH OTHER AGENCIES

Ohio's third-party recovery efforts have been hampered because of insufficient cooperation from county welfare departments and the Ohio Bureau of Workers' Compensation.

The basic source of information on possible health insurance recovery actions is the county welfare departments. For each application, redetermination, or change in public assistance status, the counties are to notify the third-party unit of the health insurance status of each Medicaid recipient. Also, as the counties pursue child support payments, they are to collect from fathers who are liable for the Medicaid expenses of their families. We found that the counties have not been diligent in providing this information or collecting Medicaid moneys from responsible fathers. Officials of the third-party unit attribute this problem to (1) the county welfare departments' lack of understanding and awareness of their third-party recovery role and (2) the low priority county caseworkers assign to these efforts.

According to State agency officials, the third-party unit has received little cooperation from the Ohio Bureau of Workers' Compensation. Recoveries from individuals on settlement of workers compensation claims is a source of third-party funds. The Workers' Compensation Bureau has refused to provide access to its medical records or to notify the third-party unit when it settles claims with injured workers. Without access to the medical records, the third-party unit cannot determine if both Medicaid and Workers' Compensation are paying Medicaid recipients' medical bills. Access to settlement proceedings would allow the unit to subrogate the claim for Medicaid-related bills.

UNEXPLORED COLLECTION POTENTIAL

While we generally agree with the unit's concentration of recovery effort in the areas of health insurance and tort actions, we believe the unit should explore other areas with recovery potential. For example, in Ohio, the third-party unit screens only claims involving gunshot wounds, renal dialysis, and ambulance runs. The State of Washington screens all Medicaid claims (except drugs) for potential third-party liability and has been saving about $2 million annually on a Medicaid program about half the size of Ohio's. We believe that Ohio could also recover more money by expanding the scope of its screening.

The unit should also consider recovering Medicaid costs from fathers liable for child support. 1/ The counties have an active program to recover child support money but have been unsuccesful in recovering Medicaid costs. We believe that Ohio could recover thousands of dollars annually by combining the third-party recovery efforts of Medicaid and child support payments.

CONCLUSIONS

The management and direction of the third-party unit should continue to be improved to maximize the effectiveness of its limited personnel resources. Also, the county welfare departments should be better informed of their role in recovering third-party funds and of the importance of their cooperation. The third-party unit should continue to explore alternatives found effective in other States.

AGENCY COMMENTS

The State agency said it agreed that third-party efforts needed to be expanded. The State also agreed that the third-party unit was improving and should continue to do so.

1/Public Law 95-142 requires the State to seek recovery of medical costs from absent parents liable for such costs and also encourages the use of the same methods for obtaining such recoveries as are used to obtain child support payments.

CHAPTER 12

POTENTIAL SAVINGS BY USING SKILLED NURSING CARE AS ALTERNATIVE TO HOSPITALIZATION

In recognition of the high cost for hospital care, Federal law requires State Medicaid programs to provide the lower cost alternative of skilled nursing services for patients who require professional nursing daily but do not require the full range of services available at hospitals. This care is provided in skilled nursing facilities that are certified by the Department of Health, Education, and Welfare and/or the States.

Ohio lacks an adequate program to provide the lower cost skilled nursing services to hospitalized Medicaid patients. As a result, many patients who could be adequately cared for in SNFs are kept in hospitals where the costs are much higher. Generally, Medicaid certified beds are available in Ohio SNFs. Ohio could save millions of dollars a year if it made SNF care available to these patients.

SKILLED NURSING CARE ALTERNATIVE NOT ALWAYS AVAILABLE TO HOSPITALIZED PATIENTS

In response to problems in placing post-hospital patients, the Ohio Hospital Association surveyed its members in August 1977 to obtain statistics on this situation. The hospitals that responded (123 of 218, or 56 percent) reported that on the day of the survey they had 223 Medicaid patients awaiting transfer to SNFs. The estimated cost for maintaining these patients in hospitals was about $38,000 per day (223 patients at $170), or $13.8 million per year. 1/ Information from one county welfare department showed that just three hospitalized patients had accumulated a combined bill of over $130,000 while the county had unsuccessfully attempted placement in SNFs.

1/The Social Security Administration estimates that by placing hospitalized patients in nursing homes, 40 percent of the per diem rate is saved. The remaining 60 percent represents fixed costs which are incurred by hospitals whether or not a bed is occupied.

This inability to place hospitalized Medicaid patients in SNFs does not mean that these facilities do not have Medicaid patients. As of June 1977 Medicaid patients filled 19,484, or 54 percent, of the 36,206 beds available in Ohio's 360 SNFs. However, only about 2,300, or 12 percent, of the Medicaid patients filling these beds were skilled care cases. The remaining 88 percent were classified as intermediate care cases. The mixing of these two types of patients in one facility is very common in Ohio because all but 12 SNFs are also certified as intermediate care facilities.

The presence of about 2,300 Medicaid patients in SNFs does not indicate that significant numbers of Medicaid patients are being transferred from hospitals to SNFs. The director of an organization that makes annual onsite reviews at Ohio's SNFs said that nearly all the skilled care Medicaid patients entered these facilities as intermediate care cases and only became skilled care cases when their health deteriorated further.

Inability to place hospitalized patients in SNFs attributed to inadequate reimbursements

All affected parties--hospitals, SNFs, and the Ohio Medicaid program--agreed that many Medicaid patients who should be transferred to SNFs remain in hospitals primarily because SNFs are unwilling to accept these patients. They all agreed this problem occurs because the State's maximum rate of $26 per patient day 1/ is not enough to cover the cost of skilled care and, therefore, a SNF finds it more profitable to fill beds with intermediate care patients, whose costs are adequately reimbursed by Medicaid.

Ohio Medicaid program officials said that they have not recommended raising the reimbursement rates because no adequate controls exist which would assure that the higher rates would be paid only for skilled care cases, as demonstrated by our review of utilization control over institutional services. (See ch. 10.)

1/Beginning in January 1978, the maximum daily rate was increased to $31. However, this is still well below the $40 to $50 per day estimated cost of skilled care.

According to hospital association representatives, the inadequate Medicaid reimbursement rates for skilled nursing care also result in an inability to transfer hospitalized Medicare patients to SNFs. The hospitals responding to the patient placement survey identified 944 Medicare patients in 123 hospitals awaiting transfer to SNFs. The estimated cost for maintaining these patients in hospitals was about $161,000 per day (944 patients at $170) or $58.6 million per year. 1/ The representatives explained that although Medicare pays full reasonable costs, SNFs are reluctant to accept Medicare patients because of the possibility they will become Medicaid patients after exhausting their maximum Medicare benefits of 100 days and their personal resources.

WAYS TO IMPROVE SKILLED NURSING CARE PROGRAM

The Ohio Medicaid program should improve its skilled nursing benefit to achieve savings by transferring appropriate Medicaid patients from hospitals to SNFs. As part of a plan to meet this objective, Ohio should:

--Modify, after adequate utilization controls are in place, the formula used to determine reimbursements for skilled care to encourage SNFs to accept hospitalized Medicaid patients requiring high levels of skilled care.

--Certify facilities or distinct parts of facilities for only SNF care or ICF care and set separate reimbursement rates for each level of care.

--Establish separate State licensing requirements for SNFs and ICFs.

--Require SNFs participating in Medicaid to participate also in Medicare.

These measures are discussed in the following sections.

1/See footnote on p. 129.

Skilled care rate formula needs to be modified

Achieving an effective skilled nursing care program for Ohio's Medicaid patients is hampered by the cost reimbursement formula used to reimburse SNFs for patient costs. All affected parties agree that Ohio's $26 per day ceiling for patient payments does not provide sufficient reimbursement to pay for expensive or high quality skilled nursing care. Although we did not attempt to estimate a rate which would be necessary, the Federal Medicare program determined in a 1976 study that reimbursements for skilled nursing care, up to a maximum of between $40 and $53 per day depending on the locality, would not necessarily be excessive. To prevent abuses, Ohio should have an effective utilization review process and a sound rate setting process operating before it revises its reimbursement formula. With higher reimbursements, Ohio must have controls which will preclude payments at the skilled nursing rate for patients neither requiring nor receiving skilled nursing care. For example, the cost for the care of 10,000 intermediate care patients misclassified as skilled care patients could cause an overpayment of $73 million per year if the skilled and intermediate rates were $45 and $25 per day, respectively. We believe that present utilization review for long-term care facilities is inadequate. (See ch. 10.)

The ability of an SNF/ICF to accept any skilled care Medicaid patients at all is likely attributable to the fact that Ohio pays an individual nursing home the same rate, regardless of whether its patients require skilled or intermediate care. The SNF/ICF can spread its costs over all patients and, in effect, have a large number of intermediate care cases subsidizing a small number of skilled care cases. How this can occur in a typical nursing home certified as both a SNF and an ICF is illustrated in the following table which shows that a $25 per day rate adequately reimburses a SNF for total patient costs even though the cost of skilled care is $50 per day because the cost of intermediate care might only be $20 per day.

Level of care	Number of Medicaid patients	Total daily cost	Average daily cost per patient	Average daily cost per all patients
Skilled care	10	$ 500	$50	
Inter-mediate care	50	1,000	20	
Total	60	$1,500		$25

Data compiled by an onsite review organization supports the existence of this cost shifting since it shows that most SNFs have several intermediate care patients for each skilled care patient. For example, in none of the 52 SNFs with at least 10 Medicaid patients visited by the review organization did the percentage of the Medicaid patients classified as skilled care exceed 26 percent.

Even if the $26 per day maximum for patients was eliminated, Ohio's reimbursement formula apparently would still preclude a SNF with a large percentage of skilled care Medicaid cases from recovering its costs. This occurred because the State reimbursement formula established a maximum allowed for professional nursing services and other nursing services (orderlies, aids, etc.) at the minimum staffing necessary to meet State licensing and certification requirements. This limitation on reimbursement is inconsistent with provisions in both the State and HEW regulations which indicate that the miminum standards are not the only criteria to use in determining the need for personnel.

The Ohio regulations state that:

> "In addition to complying with the [personnel] requirements in this regulation, each home [SNF] shall maintain sufficient additional personnel to provide adequate services and care at all times for the patients or residents admitted to or retained in the home* * *."

The Federal certification standards specify that the adequacy of the staffing pattern for SNFs is dependent on

--purposes and objectives of the facility;

--nonnursing functions performed by nursing service staff;

--intensity of illness, nursing needs, and degree of dependence of the patients;

--physical layout of the facility; and

--level of preparation and turnover rate of the staff.

Benefits of separate facilities for skilled and intermediate care patients

Ohio's policy of certifying facilities and all the beds within the facilities to serve patients needing either SNF or ICF care

--makes accounting for costs more complex and costly than if the patients were separated by type and

--is not in the best interest of the patients.

Although dual certification is not prohibited, Federal regulations identify major differences between the two types of facilities. For example, an HEW manual describing SNFs states:

> "It [a SNF] is not intended as a general nursing home benefit or extended hospital benefit. Accordingly, a SNF is a facility which provides a level of care distinguishable both from the level of intensive care ordinarily furnished by a general hospital and the level of health related care furnished by ICFs which primarily meet the needs of patients who do not require skilled nursing services."

In describing ICFs, this same HEW manual states:

> "It is important to emphasize what an ICF is not. It is not simply a different level or intensity of the same services offered by a skilled nursing facility. It is not a cheaper version of a skilled nursing facility. The differences between an ICF and a SNF lie in the kind, not the intensity of the services provided."

Establishing separate rates for skilled and intermediate patients will present the State and nursing homes with complex and costly cost allocation problems if both types of patients remain in the same facility because the needs of SNF patients differ from ICF patients. For example, skilled care patients undergo active and often complicated treatment for specific medical problems which must be performed or supervised by individuals with professional health training. By contrast, intermediate care patients primarily require care and supervision that exceeds the level of room and board, (i.e. assistance for feeding, grooming, ambulation, toilet activities, etc.) which can be provided by orderlies or aids. Establishing separate SNFs and ICFs or distinct parts of facilities dedicated to skilled care would result in separating the types of personnel needed which in turn would simplify and reduce the cost allocations needed to compute reimbursement rates.

Concerning the quality of care, the director of one of the State's annual onsite review organizations stated that it would improve the care provided to both groups if skilled and intermediate care patients were in separate facilities. He believes that with separate facilities, greater attention could be concentrated on specific problems, such as cancer, neurology, and orthopedics for the SNF group, and on senility and quality of life for the ICF group.

Savings through revision of licensing requirements

In Ohio, the same licensing requirements apply to both SNFs and ICFs. These requirements were drafted based on the needs of SNFs and are unrealistic and unnecessarily expensive when applied to ICFs. For example, Ohio's licensing regulations specify that an ICF with over 100 patients must have a registered nurse on duty at all times. By contrast, HEW specifies that an ICF's nursing services needs can be met almost entirely with less costly types of personnel, such as orderlies and aids, and require at most that one registered nurse be present for a regular 5-day work week of 40 hours. The director of one of the State's annual onsite review organizations estimates that revising licensing requirements could result in savings of $5 per day for the care of ICF patients.

Savings by requiring SNFs to obtain Medicare certification

Because skilled nursing care is appropriate for the medical conditions that afflict the aged and disabled, many Medicaid patients needing such care are also covered by Medicare. A Medicaid patient with Medicare coverage transferring from a hospital to a SNF may be eligible for the skilled nursing benefit under Medicare if he/she transfers to a SNF that is certified by both programs. The Medicare skilled nursing benefit pays 100 percent of costs for the first 20 days and costs above $15.50 per day for the next 80 days. To be eligible for the Medicare benefit, the patient must require the skilled nursing care after a hospital confinement of at least 3 days.

As of June 1977, 169 of Ohio's 360 Medicaid certified SNFs did not participate in Medicare. Thus, none of the Medicaid/ Medicare patients in the 169 SNFs had their costs reimbursed by Medicare. Obtaining Medicare certification would not impose a burden on these SNFs because the definition of skilled care and the conditions for participation are the same for both programs.

To date, the State has probably not made considerable unnecessary Medicaid payments for care of patients in SNFs not certified by Medicare because few Medicaid/Medicare patients requiring skilled care are currently being transferred from hospitals to SNFs, as shown by the statistics from the hospital association survey. However, implementing the program improvements suggested in this report should significantly increase the flow of Medicaid/Medicare patients from hospitals to SNFs and, therefore, increase the unnecessary payments because many Medicaid SNFs are not certified by Medicare.

CONCLUSIONS

Ohio is wasting millions of dollars annually because the skilled nursing benefit is not being effectively used as an alternative for high-cost hospitalization. As part of the plan to correct this situation, Ohio should revise its policies, procedures, and practices regarding the reimbursing, certifying, and licensing of SNFs and ICFs, as well as implement an effective utilization control program for institutional services.

RECOMMENDATIONS

We recommend that Ohio develop and implement a plan to improve the operation of its skilled nursing benefit to achieve savings by transferring appropriate Medicaid patients from hospitals to SNFs. As part of the plan to meet this objective, Ohio should:

--Modify, after adequate utilization controls are in place, the formula used to determine reimbursements for skilled care to encourage SNFs to accept hospitalized Medicaid patients requiring skilled care.

--Certify facilities or distinct parts of facilities for only SNF or ICF care.

--Establish separate State licensing requirements for SNFs and ICFs.

--Require SNFs certified by Medicaid to be certified by Medicare also.

AGENCY COMMENTS

The State Medicaid agency said that it agreed completely with our recommendations and that it has supported the State legislative changes necessary to implement the recommendations. The State said that the problem is that State law provides that payments to nursing homes be based on the facility's classification, not on the needs of the patient.

The State agency has modified its ceiling on nursing costs to allow staffing of about 120 percent of the minimum required staffing. As discussed on p. 133, the former limit set at the minimum required staffing level adversely affected the availability of skilled nursing services.

CHAPTER 13

CHILD PREVENTIVE CARE PROGRAM

NOT OPERATING OPTIMALLY

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program requires a State to be actively involved in preventive health care for children eligible for Medicaid by identifying medical problems through physical examinations and early treatment of these problems. As a part of EPSDT, a State must also provide eyeglasses, hearing aids, other treatment for visual and hearing defects, and some dental care. When the program was enacted, the Congress believed that it could greatly reduce the costs of medical care in the long run. However, in Ohio the potential savings through EPSDT are jeopardized because even though the program meets minimum Federal requirements

--many eligible children have not participated in the program,

--operations at some locations have not been adequately staffed, and

--the State lacks data needed to (1) determine if eligible children receive screening tests and needed treatment and (2) evaluate program progress.

OHIO'S PROGRAM MEETS MINIMUM FEDERAL REQUIREMENTS

The Social Security Amendments of 1967 required EPSDT to be implemented by July 1, 1969, in every State that had a Medicaid program. However, the Department of Health, Education, and Welfare was slow in developing EPSDT regulations and the States were concerned about how it would affect their budgets. EPSDT regulations became effective February 7, 1972, about 2-1/2 years after the law stipulated that the program be fully implemented and 3 years after EPSDT was authorized by law. The regulations required States to start implementing EPSDT, at least for children under age 6, but allowed States until July 1, 1973--4 years after the July 1969 required implementation date--to fully implement services for all children under age 21.

In October 1972 the Social Security Amendments of 1972 were enacted. Title II of the amendments, as implemented by regulations, requires the Secretary of HEW to reduce Federal sharing in State Aid to Families with Dependent Children payments by 1 percent for quarters starting in fiscal year 1975 if a State fails to

--inform in writing, at least annually, all eligible AFDC families of the availability of screenings and where and how screenings can be obtained;

--assist those AFDC eligibles to obtain requested screenings, normally within 60 days of the request; and

--arrange for treatment of conditions uncovered during screening, normally within 60 days of the screening.

HEW's regional office has periodically monitored Ohio's EPSDT efforts and according to its January 1977 report, the program was in compliance with the law. Specifically:

--The requirement for informing all recipients had been met by an annual notification letter sent in July 1976.

--Outreach efforts in each of the counties reviewed acquaint recipients with the availability of transportation and other services which they may need to take advantage of screening and treatment.

--Screening or treatment in each of the counties reviewed was usually accomplished within 60 days.

MANY CHILDREN DO NOT PARTICIPATE IN THE PROGRAM

Ohio's EPSDT program began in September 1973 with a pilot program in Summit County (Akron) and was implemented statewide in July 1974. Thus, Ohio failed to meet even the HEW implementation deadline because its pilot EPSDT program was not started until 3 months after the HEW-required date of July 1, 1973, for full implementation. As of March 1977 the program was being administered by 7 State staff members and 175 full- and part-time personnel at Ohio's 88 county welfare departments.

Under Ohio's EPSDT program guidelines, all children are to be screened, regardless of age, as soon as they become eligible for Medicaid. Thereafter, individuals may receive screening examinations annually but should be periodically screened at least at ages 1, 4, 7, 11, and 16. Treatment, if necessary, is to be provided immediately after screening.

Ohio accumulates data on the number of children receiving screenings, except for newborns, as a byproduct of its claims processing system. While its percentage of eligible children screened approximates the national average, Ohio still has a long way to go, as shown in the following table.

Year ending	Eligible children	Screenings		Percent screened	
		Number	Cost	Ohio	U.S. average (note a)
b/June 1974		417	$13,616		
June 1975	442,192	28,705	1,062,840	6	11
June 1976	476,854	64,888	2,462,474	14	14
June 1977	466,654	58,660	2,275,294	13	c/NA

a/ Includes screening data for newborns when available.
b/ Pilot program during fiscal year 1974.
c/ Not available.

Thus, Ohio screened only 13 percent of the eligible children during the year ended June 30, 1977. At this rate, Ohio would need about 8 years to screen all children eligible for the program. The State did not accumulate reliable data on other aspects of the EPSDT program, such as the (1) number of children referred for treatment, (2) conditions identified by screenings (e.g., problems with hearing or vision and lead poisoning), and (3) number of children receiving treatment.

OHIO'S PROGRAM LACKS SUFFICIENT STAFF AT SOME LOCATIONS

Each county welfare department is responsible for establishing and operating EPSDT within its own area. According to the State Chief of the Bureau of EPSDT, some county welfare departments have not assigned sufficient staff to EPSDT activities to effectively operate the program. The following table demonstrating this problem was prepared from data compiled by the EPSDT Bureau.

EPSDT Staffing Levels
at Selected Counties

County	Eligible children	EPSDT staff	
		Number	Percent of time spent on EPSDT
Mahoning (Youngstown)	12,400	2	100
Stark (Canton)	10,400	2	45
Richland (Mansfield)	3,800	2	10
Hocking (Logan)	800	1	10

The EPSDT Bureau Chief attributes the lack of staff to the fact that the Ohio Medicaid program does not provide separate funding for EPSDT operations, so most county personnel assigned to the EPSDT program are funded from the county's social services budget. Because separate funding is not provided, some counties see EPSDT as a short-term program requiring minimal commitment of staff time and resources.

DATA NEEDED TO IDENTIFY AND TRACK CHILDREN AND EVALUATE PROGRAM PROGRESS

Compliance with the technical requirements of the Federal penalty provision does not necessarily assure that a State's EPSDT program is operating effectively. For example, program operations in Ohio were severely hampered by a lack of data required by State program personnel and county welfare departments.

Data needed for effective operations

Ohio's EPSDT program requires computer-generated data to assure an effective program for children and for program management.

County welfare departments need computer support to effectively track children receiving screenings to assure that needed treatment is provided. Without such data, they do not have reliable information as to whether treatment has or has not been given. This information normally cannot be obtained manually.

County welfare departments--particularly in counties with large populations of eligible children--also need computer support to effectively identify, notify, and track children upon reaching the ages of 1, 4, 7, 11, and 16 for periodic rescreening. As indicated by the following rescreening workload statistics at several large counties, the sheer volume necessitates computer support.

County	Eligible children (May 1977)	EPSDT outreach staff	Number of rescreenings due in 1977 Year	Month	Workload per staff per month
Cuyohoga (Cleveland)	81,737	11	22,775	1,898	173
Franklin (Columbus)	44,338	5	12,550	1,046	209
Hamilton (Cincinnati)	37,786	8	10,762	897	112

A State's EPSDT program must be evaluated periodically by its managers to ensure that it is effective both statewide and in counties. According to HEW, administrators monitoring EPSDT programs should have sufficient data to answer the following questions at both the State and county levels.

--Of all children eligible for the EPSDT program, how many have been identified and notified of the availability of services?

--Of all children requesting screening, how many have received each of the screening tests and procedures appropriate for their ages?

--Of all children who have received the appropriate screening tests and procedures, how many have been found abnormal or suspect on each of the screening procedures?

--Of all children found to be abnormal or suspect by screening procedures, how many have received recommended diagnostic and treatment services?

HEW believes the last item should be the major factor in evaluating the effectiveness of an EPSDT program because any instance where a child with a significant health problem identified through the screening program has not received adequate treatment represents a program failure.

Lack of needed data hampers operations

Ohio's EPSDT program did not have the computer-generated data needed to assure effective services to children and for program management.

Officials at two of the larger county welfare departments said that after receiving a copy of the screening reports from physicians identifying needed treatment, their efforts are limited to contacting parents to see if the children have obtained the treatment or need assistance to obtain it. Officials of one county said that this action alone does not constitute "tracking" which they believe also requires independently obtained data showing whether treatment has or has not been given. Concerning periodic rescreening, officials of the other county said that because of a lack of computer support, they do not even attempt to contact families as their children reach the appropriate age for rescreening. Instead, they said their EPSDT staff concentrated on (1) explaining the program to newly eligible recipients, (2) arranging for treatment to be provided to children after screenings, and (3) recruiting providers.

The data available to State administrators for EPSDT program management purposes at the time of our fieldwork was limited to a monthly report prepared with data gathered manually by each of Ohio's 88 counties. This report did not contain sufficient data to adequately answer any of the questions cited on page 142. In these reports, the counties indicated for EPSDT services only the number of

--children whose parents were notified of the program and whether or not they agreed to have their children participate and

--screening invoices received from providers and the number of children these reports show need to be referred for further diagnosis or treatment.

The number of children screened was the only data on these reports which could be verified from data available elsewhere. As shown in the following table, a comparison of the reported data from counties with data generated by Ohio's claims processing operations shows that for the two counties we checked, the county data submitted during 1976 was inaccurate.

	Number of screenings			
	County reports	Claims processing	Difference	Percent difference
Franklin (Columbus)	8,061	5,228	2,833	54
Hamilton (Cincinnati)	6,228	5,265	963	18

Although need is recognized, computer data is not provided

The State has recognized that the EPSDT program needs computer support. In fact, in 1973 the State developed a sophisticated information system which, according to the State EPSDT staff, would adequately meet the data requirements to better assure an effective program for children and for program management purposes. However, this system was not used because the State changed computer equipment and decided to assign its limited programing capability to higher priority projects.

As of July 1977, Ohio had not established a target date for implementing the information system. Instead, the State was testing a considerably less complex computer-generated information system which the EPSDT program would use until the more sophisticated system is implemented. This temporary system should provide some information useful to county welfare departments, but it will not adequately meet their information needs. For example:

--To identify children due for rescreening, the system will produce a monthly listing by county of children reaching the ages of 1, 4, 7, 11, and 16. However, the temporary system lacks several significant features intended for the permanent system that would reduce the activities county welfare departments must now

perform manually. These features include a computer-generated notification letter to parents and an exception report that lists children previously identified for screening but not screened.

--Under the temporary system the only support for tracking to assure that treatment is provided is a computer-generated report of the medical care provided to individual children after screening. This temporary system does not tell EPSDT personnel whether the medical care provided related to problems identified during screening nor does it identify children with medical problems that have not been treated. Accordingly, even with this data, EPSDT personnel will not be sure whether or not necessary treatment was provided after screening.

CONCLUSIONS

Many eligible children have not participated in Ohio's EPSDT program, and operations at some county welfare departments have not been adequately staffed. In addition, Ohio's EPSDT program was hampered by a lack of essential computer-generated data which impaired the ability of the State to (1) serve its recipients and (2) evaluate program results. Without such data, the State cannot determine who is and who is not being adequately served or adequately evaluate and direct the program. As a result, the program's savings potential from preventive health care for children is jeopardized.

RECOMMENDATION

We recommend that Ohio provide the necessary staffing and computer data support needed to improve the effectiveness of its EPSDT program.

AGENCY COMMENTS

The State Medicaid agency agreed with our conclusions and recommendation. The State did not list any specific actions it was taking to implement the recommendation.

The State also commented that it believes that the EPSDT program is a mandated program that represents national concerns and/or a national commitment. As such, the State believes Federal sharing in EPSDT costs should be increased

as it was for similar programs. The State cited as examples the Federal requirement for family planning services under Medicaid shared at the 90 percent rate and the social services program under title XX of the Social Security Act shared at the 75 percent rate.

APPENDIX I

JAMES A. RHODES
Governor
State of Ohio

KENNETH B. CREASY
Director
CHARLES E. HOGGLE
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DEPARTMENT of PUBLIC WELFARE

OFFICE OF THE DIRECTOR
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April 28, 1978

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

Dear Mr. Ahart:

The Ohio Department of Public Welfare appreciates the opportunity that has been provided to review the General Accounting Office proposed report to the State of Ohio entitled "Improved Administration Could Reduce the Costs of Ohio's Medicaid Program," and the opportunity to make written comment concerning the report. Our understanding is that the department's comments will be incorporated, in whole or in part, in the final report made by GAO. Although we realize that some further rewriting of the report may be accomplished, it should be noted that the department's comments were constructed in April 1978, and relate to the version before us at that time.

As you are aware, the comprehensive review of Ohio's Medicaid program that is represented by the proposed report was requested by a number of Ohio's elected public officials. In late summer 1976, the Ohio General Assembly passed legislation which, among other things, called upon the Ohio congressional delegation to request a GAO review of the state's Medicaid program. Also, the Co-chairmen of the Ohio General Assembly's Joint Select Committee of Welfare requested Ohio's congressional delegation to seek a GAO review, which many of them did. In addition, Governor James A. Rhodes requested GAO to conduct a comprehensive review of the state's Medicaid program.

Ohio is obviously interested in developing the best possible methods of administering Medicaid, and has constantly sought improved methods and techniques. Consequently, the department has looked forward to the review as another tool to be used in upgrading the ongoing effort toward improved management. We appreciate, also, the fact that a full review of one state's entire Medicaid program has not been done before, and that the GAO, the Congress and other states that struggle with the same Medicaid problems that face Ohio might benefit from, and be assisted by, what is revealed by a comprehensive review of a single state program. The department, therefore, hopes that all can benefit in some way from the proposed GAO report.

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Attached is a copy of the department's comments concerning the proposed report. Our review has identified some areas where factual errors exist. However, the most severe problem, as might be expected from such a large effort that involves many staff, is the unevenness of the material. Some chapters appear accurate and straightforward. Other chapters, notably the second, seem to be needlessly inflammatory and slanted.

A large concern of the department relative to the proposed document is that it relates many problems which no longer exist in Ohio, yet manages to convey the impression that they do, in fact still exist. Because of the passage of time between the date the review was undertaken and the date the report will be released, I believe it is essential for the GAO to update the review. Indeed, much change is taking place in the administration of Ohio's Medicaid program, and it should not require an inordinate amount of effort for the GAO to verify and note the changes and improvements that have occurred in Ohio's program.

The department strongly believes that any proposed report such as is represented by the GAO document should be balanced. Those items which are reflective of federal ambiguity should be clearly labeled. The impressions conveyed by the document too frequently suggest that the problems identified are the consequence of actions and choices freely made by the department.

Also, the report should place the Ohio system in proper perspective in comparison with other states. It has been our experience that Ohio has done many things rather well; and even our shortcomings represent circumstances that are to be found in many other states. Somehow such a perspective ought to be reflected in the report. Indeed, if other states do not have problems in common to Ohio's in Medicaid, then GAO's hope that the report will be of help to them is groundless.

I am happy to advise that fourteen (14) of the recommendations made in the GAO review have already been accomplished by the department. As I indicated earlier, a great deal is happening in the administration of Ohio's Medicaid program, and in the course of our continuing effort to upgrade management of the program, these advances have been made since the GAO review was commenced. Twelve (12) other recommendations are proposals which the department intends to implement. Four (4) changes proposed in the review concern practices by the department that have been necessary to comply with existing state law. The department several months ago recommended to the appropriate legislative bodies that changes in state law were desirable so that the department could make the necessary changes in Medicaid management. Two (2) of the GAO review recommendations are in the process of being implemented in Ohio. Two (2) other recommendations require appropriation of funds before the department will have a capability to implement.

This department will utilize the GAO findings, as best it can, to further build better management into Ohio's Medicaid program. I hope that the comments the department has provided will be given proper weight by your agency. In any event,

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this department is prepared to discuss the report and the state agency's comments in depth with your staff. Where appropriate, I trust that Ohio's comments will be incorporated into the body of the final report. Where this is not possible, it is presumed that the department's observations will appear following each chapter's recommendations.

Sincerely,

KENNETH B. CREASY
Director

KBC:dh
Enclosures

GAO note: The detailed comments are not included here because of their length. However, they were considered in finalizing this report.

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