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Ohio's Medicaid Program: Problems Identified Can Have National Importance. HRD-78-98A; B-164031(3). October 23, 1978. 11 pp.

Report to Secretary, Department of Health, Education, and Welfare; by Elmer B. Staats, Comptroller General.

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Organization Concerned: Social Security Administration; Ohio.
Congressional Relevance: House Committee on Interstate and Foreign Commerce; Senate Committee on Finance.

A comprehensive review of Ohio's medicaid program identified two issues that may have national importance: (1) the misleading statistics reported by the medicaid quality control program which overstate potential savings available from eliminating eligibility determination errors; and (2) the unavailability of skilled nursing services to medicaid patients which results in unnecessary hospital expenditures. Findings/Conclusions: Ohio uses a quality control system developed by the Department of Health, Education, and Welfare (HEW) to help insure proper and correct expenditures of public assistance funds by identifying unacceptable performance and ineffective policies and taking corrective action. A review of cases found ineligible by Ohio's quality control review showed that determinations were generally correct, but the procedures HEW requires the States to use do not differentiate between technical and substantive errors. Therefore, true program losses due to ineligibility and potential savings available from eliminating eligibility determination errors are overstated. The availability of skilled nursing facility (SNF) services to medicaid and medicare patients in Ohio has been adversely affected because of the State's relatively low limits on SNF reimbursement. Recommendations: The Administrator of the Health Care Financing Administration should: revise medicaid quality control study procedures to include, in reporting results of these studies, an estimate of potential savings available from elimination of medicaid eligibility determination errors; assist Ohio in improving its reimbursement system for skilled nursing services in order to increase their availability; and determine if other States' reimbursement systems for SNFs are resulting in problems like those in Ohio and assist any State with these problems in improving their skilled nursing services program. (RRS)

8063

REPORT BY THE

Comptroller General

OF THE UNITED STATES

Ohio's Medicaid Program: Problems Identified Can Have National Importance

GAO's review of Ohio's Medicaid program identified two issues which could have national importance and warrant the attention of the Department of Health, Education, and Welfare. They are

- --misleading statistics reported by the Medicaid quality control program which overstate potential savings available from eliminating eligibility determination errors and
- --the unavailability of skilled nursing facility services to Medicaid and Medicare eligibles which results in millions of dollars in unnecessary hospital expenses.

GAO recommends that HEW

- --revise its quality control study procedures and
- --assist Ohio, and any other State having problems with skilled nursing services, in improving the reimbursement systems for such services.

HRD-78-98A
OCTOBER 23, 1978

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

B-164031(3)

The Honorable
The Secretary of Health,
Education, and Welfare

Dear Mr. Secretary:

The Ohio Legislature, the Governor of Ohio, and many members of the Ohio congressional delegation asked us to undertake a comprehensive review of Ohio's Medicaid program. During that review we identified several problems with the State's administration of the program. These problems and our recommendations are being reported separately to the State. 1/

We identified two issues we believe have national importance and warrant your attention

--the misleading statistics reported by the Medicaid quality control program which overstate potential savings available from eliminating eligibility determination errors and

--the unavailability of skilled nursing services to Medicaid patients which results in unnecessary hospital expenditures.

MEDICAID QUALITY CONTROL REPORTS OVERSTATE POTENTIAL SAVINGS

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

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1/Comptroller General's Report to the State of Ohio, "Improved Administration Could Reduce the Costs of Ohio's Medicaid Program," HRD-78-98.

--continually reviewing recipient eligibility 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 action to reduce errors.

Our review of the cases found ineligible by Ohio's quality control review showed that the determinations were generally correct. However, we also found that the procedures HEW requires the States to use in making the quality control studies and reporting the results does not differentiate between technical errors and substantive errors. Therefore, true program losses due to ineligibility and potential savings available from eliminating eligibility determination errors are overstated. 1/

For the period 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 causing ineligibility, our $15.2 million estimate probably overstates Medicaid funds which could be saved by eliminating ineligibles.

Technical versus substantive errors in eligibility

Errors identified during the quality control review process are tabulated by number and cause and projected to total expenditures covered by the Medicaid quality control program. The data are consolidated in semiannual

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1/In a previous report entitled, "Legislation Needed to Improve Program for Reducing Erroneous Welfare Payments" (HRD-76-164, Aug. 1, 1977), we found that a similar problem existed in the method for reporting savings associated with reduced Aid to Families with Dependent Children (AFDC) ineligibles under AFDC's quality control program.

reports to HEW showing, 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 in terms of what could be saved if the errors were eliminated.

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 persons 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 discrepancy does not result in the recipient losing his or her Medicaid eligibility.

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

While a mechanism does exist in Ohio to assign the excess resources to the cost of care, most county welfare departments were 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. However, HEW's quality control reporting criteria does not differentiate between technical and substantive eligibility errors. Consequently, the computations of program error rates and related dollar losses 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	14	$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 then adjusted the amounts the quality control study showed to have been erroneously paid to include only the amount of funds which could be saved by eliminating ineligibility. For example, quality control found one $4,200 claim to be ineligible for payments because the recipient had a savings account which exceeded the $300 limit by $18.77. Quality control classified the entire payment as erroneous, but since the person would have to spend only $19.00 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 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 lowered their resources below the applicable limits without lowering Medicaid expenditures.

To determine if the overstating of erroneous Medicaid payment problems were 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 other States because many of the ineligible cases resulted from the same reasons. Specifically

--57 percent of the cases were ineligible because the liquid asset limits were exceeded and

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

HEW reported estimated losses of about $1 billion for the period 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 assistance. For the January to June 1977 period, the ineligibility rate had fallen to 7.8 percent.

The formula prescribed by HEW for computing case error and program loss in Ohio's AFDC program is similar to the one used in the State's Medicaid program. This formula does not differentiate between those errors which are substantive--the elimination of which would lead to savings in public assistance payments--and those which are not. Consequently, reported program losses may overstate potential savings from eliminating ineligibility. 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.

HEW has recently changed the required Medicaid quality control program. The changes include (1) a different method for selecting cases to be reviewed and (2) addition of tests to the quality control procedures to assure that third-party liability cases are correctly handled and that only appropriate claims are paid at the authorized amount. These changes should improve the usefulness of quality control studies. However, the methods for estimating overpayments, with their implication of potential savings, have not been changed from those outlined above.

UNAVAILABILITY OF SKILLED NURSING SERVICES

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 (SNFs) that are certified by HEW and/or the States.

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 to place them 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 represent 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.

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 them. They all agree 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 changing the reimbursement system for SNFs to one that pays full reasonable costs because no adequate controls exist which would assure that the higher rate would be paid only for skilled care cases. Our review of utilization control over institutional services confirmed this belief.

If Ohio or any other State is to pay full reasonable costs to a SNF, it is of paramount importance that they have an effective utilization review system for SNF services. This is so because if patients who only require an intermediate level of care are allowed to be placed in a SNF, the cost of care for such patients will be increased

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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.

tremendously. 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 in Ohio is inadequate.

The problem of not being able to transfer hospitalized Medicaid patients to SNFs may well result in an even greater problem for the Federal Medicare program. According to hospital association representatives, the inadequate Medicaid reimbursement rate for skilled nursing care also results 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 per day) 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 benefit of 100 days and their personal resources.

Many other States also limit reimbursements to SNFs at relatively low upper limits. For example, California limits SNF reimbursements to $27.77 per-patient-day and Florida limits them to $630 per-patient-month. While we do not know if SNF reimbursement limits in other States have had an impact on the availability of Medicaid and Medicare SNF services as they have in Ohio, we suspect they have.

We have also noted that several Professional Standards Review Organizations, which are responsible for reviewing the utilization of hospital care of Medicaid and Medicare patients in many areas of the Nation, have reported that their ability to reduce hospital costs under the programs has been limited because of the difficulty in transferring relatively sick patients to SNFs.

1/See footnote on page 7.

CONCLUSIONS

The procedures HEW perscribes for the States to use in reporting the findings of Medicaid quality control studies result in misleading statistics. Because the procedures do not differentiate between substantive and procedural errors which cause recipient ineligibility, reported dollar losses due to ineligibility do not represent savings which could result from eliminating the errors. We believe that many people misunderstand the meaning of reported payments for Medicaid ineligibles and interpret them as potential savings if error rates are reduced or eliminated. We believe HEW should also report an estimate of savings attainable from eliminating errors, computed in a manner similar to the one we used.

The availability of SNF services to Medicaid and Medicare patients in Ohio has been adversely affected because of the State's relatively low limits on SNF reimbursement. Millions of dollars in extra program costs for hospital services result.

We believe that the same problem may exist in other States. Many States have placed relatively low upper limits on nursing home reimbursement rates which could also be affecting the States' and Medicare's abilities to transfer hospitalized recipients to SNFs when that level of care is appropriate.

RECOMMENDATIONS

We recommend that the Secretary of HEW direct the Administrator of the Health Care Financing Administration to:

--Revise Medicaid quality control study procedures to include, in reporting the results of these studies, an estimate of the potential savings available from elimination of Medicaid eligibility determination errors.

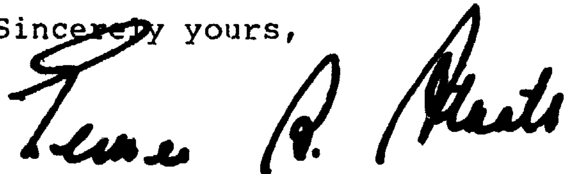
--Assist Ohio in improving its reimbursement system for skilled nursing services in order to increase their availability after assuring an adequate utilization review program for SNFs is in place.

--Determine if other States' reimbursement systems for skilled nursing care are resulting in problems like those in Ohio and assist any State with these problems in improving their skilled nursing services program.

As you know, section 236 of the Legislative Reorganization Act of 1970 requires the head of a Federal agency to submit a written statement on actions taken on our recommendations to the Senate Committee on Governmental Affairs and the House Committee on Government Operations not later than 60 days after the date of the report and to the House and Senate Committees on Appropriations with the agency's first request for appropriations made more than 60 days after the date of the report.

Copies of this report are being sent to the Chairmen, Senate Committee on Governmental Affairs, the House Committee on Government Operations, and the House and Senate Committees on Appropriations; the Director of the Office of Management and Budget; the Inspector General of HEW; the Administrator of the Health Care Financing Administration; and other interested parties.

Sincerely yours,



Comptroller General
of the United States