REPORT TO THE HUMAN RESOURCES TASK FORCE
HOUSE COMMITTEE ON THE BUDGET

090087

BY THE COMPTROLLER GENERAL OF THE UNITED STATES

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History Of The Rising Costs Of The Medicare And Medicaid Programs And Attempts To Control These Costs: 1966–1975

Department of Health, Education, and Welfare

The primary reason for the $10.4 billion rise in the cost of providing Medicare and the $9.8 billion rise in Medicaid between fiscal years 1967 and 1975 was inflation (and probably the use of more extensive types of services) plus increases in the number of people covered by each program and in the use of services.

In addition, covering of additional types of services resulted in increased costs, especially for Medicaid.

GAO has made 83 recommendations in reports to the Congress, its committees and members, and the Secretary of HEW designed to control unnecessary Medicare and Medicaid costs. While in most cases HEW has taken at least some action to carry out these recommendations, many of them have not been fully implemented.

HEW has often been slow in implementing by regulation laws passed by the Congress to help control Medicare and Medicaid costs.

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

B-164031(3)

The Honorable Parren J. Mitchell
Chairman, Human Resources Task Force
Committee on the Budget
House of Representatives

Dear Mr. Chairman:

This report discusses the cost increases that have occurred in the Medicare and Medicaid programs since their inception and the reasons for these increases. Information on the Department of Health, Education, and Welfare's implementation of the Medicare and Medicaid cost control provisions of the 1967 and 1972 Amendments to the Social Security Act and of GAO's recommendations to control unnecessary costs is also included. Administrative actions taken by HEW to control program costs are summarized in the report.

The report is in response to your request of August 5, 1975. As requested by your office, comments were not obtained from HEW on the matters discussed in the report.

Two recommendations for legislative action are included in the report.

Sincerely yours,

Elmer B. Staats

Comptroller General
of the United States

Contents

ABBREVIATIONS

EPSDT	Early and Periodic Screening, Diagnosis and Treatment
GAO	General Accounting Office
HEW	Department of Health, Education, and Welfare
HMO	Health Maintenance Organization
PSRO	Professional Standards Review Organization
SSA	Social Security Administration
SRS	Social and Rehabilitation Service

COMPTROLLER GENERAL'S REPORT TO THE HUMAN RESOURCES TASK FORCE OF THE COMMITTEE ON THE BUDGET HOUSE OF REPRESENTATIVES

HISTORY OF THE RISING COSTS OF THE MEDICARE AND MEDICAID PROGRAMS AND ATTEMPTS TO CONTROL THESE COSTS: 1966-1975

Department of Health, Education, and Welfare

D I G E S T

Reasons for Medicare Cost Increases

Between fiscal years 1967 and 1975, the cost of providing Medicare services increased $10.4 billion from $4 billion to $14.4 billion. Most of this was related to hospital benefits, the cost of which increased $7.4 billion, from $2.7 to $10.1 billion. Three factors accounted for this:

--$6.2 billion due to inflation and, perhaps, more extensive types of hospital services;

--$870 million because of a 4.7 million person increase in eligibles; and

--$315 million due to a 9 percent increase in the use of hospital benefits by eligibles. (See pp. 4 through 11.)

Reasons for Medicaid Increases

Total Federal and State costs of Medicaid services increased $9.8 billion between fiscal years 1967 and 1975, from $2.3 to $12.1 billion. Because of incomplete data it was not possible to determine all the reasons for the increases or the amount of the increase due to each. However, available data indicated that the following factors led to increased costs:

--inflation, for example the reported average cost per day of inpatient hospital care increased 40 percent in California and 102 percent in New Mexico;

--increase in the number of States with Medicaid programs, from 28 States and jurisdictions in January 1967 to 53 programs by August 1972;

--more States included Medicaid coverage of the medically needy (those with incomes sufficient for their maintenance needs but not their medical needs);

--an increase in the number of people receiving cash assistance and thus automatically eligible for Medicaid (from 7.5 million cash assistance recipients in fiscal year 1967 to 15.8 million in June 1975); and

--some States elected to cover additional optional benefits under their programs. (See pp. 11 through 15.)

HEW Response to GAO Recommendations

GAO has issued 31 reports to the Congress, its Committees, and the Secretary of HEW with recommendations for controlling the costs of the Medicare and/or Medicaid programs. GAO made 83 recommendations, 29 of which have been fully or substantially carried out by HEW, 47 have been partially fulfilled, and 7 have not been implemented. Two recommendations were not implemented because of congressional actions. (See pp. 16 and 17.)

Congressional and HEW Cost Control Efforts

The Congress passed two important acts to help control Medicare and Medicaid costs--the 1967 and 1972 Amendments to the Social Security Act. HEW has been slow in issuing regulations and carrying out many of the provisions of these acts.

Of the 37 sections in these two laws relating to cost control, HEW implemented by regulation 4 sections before their effective date, and:

--3 sections from the effective date to 6 months later;

--5 sections from 6 months to a year later;

--12 sections one to two years later; and

--9 sections more than 2 years later.

One section was a special case which gave the Secretary of HEW authority to make changes in the reimbursement method for durable medical equipment but did not require the Secretary to take action.

Two sections had not been implemented as of December 1975, and the effective date of one section has not arrived. (See pp. 18 and 19.)

HEW has taken a number of actions to help control Medicare and/or Medicaid costs. However, HEW could not provide an estimate of costs saved by these actions. (See pp. 19 through 26.)

Suggested Legislative Actions

GAO recommends that the Congress enact HR 8717, a bill to amend title XVIII of the Social Security Act to make it clear that payments may be made under the supplementary medical insurance program for wheelchairs and other durable medical equipment furnished on a lease-purchase basis. (See pp. 29 and 30.)

GAO also suggests that the Congress consider repealing section 263(d)(5) of P.L. 92-603 which authorized the Railroad Retirement Board to contract with carriers to pay for Medicare claims for its beneficiaries. The use of a separate carrier to process and pay claims for a special, small group of beneficiaries seems inherently duplicative in administrative costs. (See p. 31.)

CHAPTER 1

INTRODUCTION

On August 5, 1975, the Chairman, Human Resources Task Force, House Committee on the Budget, requested GAO to provide information on the Medicare and Medicaid programs. Specifically, the Chairman asked for information on

--the increases in the costs of the Medicare and Medicaid programs and the reasons for the increases;

--prior GAO recommendations relating to controlling unnecessary costs of the programs, the extent of HEW's implementation of the recommendations, and the impact of the recommendations on the programs;

--congressional and HEW efforts to control the costs of the programs and the results of these efforts; and

--proposals for further legislative or administrative actions to reduce the increase in Medicare and Medicaid costs.

See Appendix I for the Chairman's letter.

THE MEDICARE PROGRAM

Medicare, authorized by title XVIII of the Social Security Act, is a health insurance program for the aged and disabled. The Medicare program is divided into two parts

--part A, Hospital Insurance, which covers inpatient hospital services and post-hospital care in a skilled nursing facility or in a patient's home; and

--part B, Supplementary Medical Insurance, which covers physicians services, outpatient x-ray and laboratory services, durable medical equipment, ambulance services, prosthetic devices, and home health care.

Medicare benefits began on July 1, 1966, except for skilled nursing facility benefits which began six months later. Initially, individuals aged 65 and over were covered by the program. Beginning July 1, 1973, coverage was extended to (1) disabled individuals under age 65 after they were eligible for social security or railroad retirement disability benefits for at least 24 months and (2) insured individuals and their families under age 65 with chronic kidney disease. Part A is principally financed by taxes on earnings paid by employers, employees and self-employed persons. Enrollment in part B is voluntary and the program is financed by monthly premium payments ($6.70 in 1975) by enrollees together with appropriations from the general revenues of the Federal Government.

The Secretary of Health, Education, and Welfare (HEW) has delegated responsibility for administering the Medicare program to the Commissioner of the Social Security Administration (SSA). Field activities of the Medicare program are carried out by regional representatives of the SSA's Bureau of Health Insurance.

To help administer Medicare benefits HEW has contracted with public and private organizations called intermediaries and carriers. Intermediaries generally make payments under parts A and B on the basis of "reasonable cost" to institutional providers of services, such as hospitals, skilled nursing facilities and home health agencies. Carriers make payments under part B on the basis of "reasonable charges" to doctors and various suppliers.

THE MEDICAID PROGRAM

Title XIX of the Social Security Act authorizes the Medicaid program which began on January 1, 1966. It is a grant-in-aid program under which the Federal Government pays from 50 to 78 percent of State costs for medical services provided to people who are unable to pay for their medical care. Initially, six States and Puerto Rico had Medicaid programs but this has grown to forty-nine States, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands. Arizona is the only State without a Medicaid program.

When the Medicaid program began, participating States were required to provide to individuals eligible under their Medicaid programs the following services: inpatient and outpatient hospital, laboratory and x-ray, skilled nursing home and physician. Subsequent amendments to title XIX have required the States to provide home health care, family planning services, and early and periodic screening,

diagnosis, and treatment of eligible individuals under the age of 21. Additional services such as dental care and prescribed drugs may be included under a Medicaid program if a State so chooses.

Two groups of people can be covered by Medicaid. The first group, known as the categorically needy, are people who receive, or are eligible to receive, public assistance under one of the cash assistance programs. The categorically needy must be covered by the State's Medicaid program. A State can also elect Medicaid coverage for the second group--the medically needy. These are individuals who meet all of the requirements of a cash assistance program except that their income or resources exceed the cash assistance level by not more than one third.

The Secretary of HEW has delegated the responsibility for the administration of the Medicaid program to the Administrator of the Social and Rehabilitation Service (SRS). Authority to approve grants for State Medicaid programs has been further delegated to SRS Regional Commissioners who are responsible for the field activities of the program.

States have the primary responsibility for initiating and administering their Medicaid programs. The nature and scope of a State's Medicaid program is contained in a State plan which, after approval by a Regional Commissioner, provides the basis for Federal grants to the State. The Regional Commissioners are responsible for determining whether the State programs are being administered in accordance with existing Federal requirements and the provisions of the States' approved plans.

CHAPTER 2

REASONS FOR THE INCREASED PROGRAM COSTS OF MEDICARE AND MEDICAID

The primary cause for the increase in Medicare costs since the inception of the program has been inflation. Increased numbers of beneficiaries, and an increase in the utilization of services by beneficiaries have also contributed to the growth in Medicare costs.

Medicaid cost increases can be attributed to a number of reasons. The two main reasons are an increase in the number of people eligible for benefits and inflation. Another contributing factor was the election by some States to include additional optional services under their programs.

COST INCREASES IN MEDICARE 1/

The cost of the Medicare program has more than tripled since its first year of operation. 2/ During fiscal year 1967, part A benefits cost about $2.9 billion for its 19 million eligibles and part B benefits approximately $1.2 billion for the 18 million people enrolled.

By fiscal year 1975, Medicare costs had increased to $10.5 billion for the 23.7 million part A eligibles and $4 billion for the 23.2 million part B enrollees. Thus, while the number of part A eligibles increased only 25 percent, part A costs increased 263 percent, (an average annual rate of 17.5 percent). Also, part B costs increased 243 percent, (an average annual rate of 16.7 percent) while part B enrollees increased only 30 percent.

1/This section deals only with the costs of benefits. For information on claims processing costs see Appendix VI.

2/All Medicare data presented in this chapter was provided by the Office of the Actuary, SSA and is on an incurred basis, that is, the data is based on the date the service was provided and not the date it was paid for. Since we analyzed utilization data, it is more important to know when the services were provided than when they were paid for. The data in this report may not agree with data in other GAO reports or HEW publications which contains data on a date of payment basis.

The cost of providing benefits, the number of people eligible for benefits, the cost per eligible enrollee and the percent change in this cost for fiscal years 1967 through 1975 are presented in table 1 for part A and table 2 for part B.

TABLE 1

Medicare Hospital Insurance Experience: Fiscal Years 1967-75 (PART A)

Fiscal year	Total cost (millions)	Total number of eligibles (millions)	Cost per eligible	Percent change in cost per eligible
1967	$ 2,886	19.0	$151.70	-
1968	3,841	19.4	198.35	30.8
1969	4,641	19.6	236.21	19.1
1970	4,992	19.9	250.30	6.0
1971	5,602	20.3	276.44	10.4
1972	6,161	20.6	299.28	8.3
1973	6,743	20.9	322.26	7.7
1974 (note a)	8,201	23.1	354.96	10.1
1975 (note a)	10,471	23.7	442.34	24.6

a/Includes data for the disabled and those with chronic kidney disease. These individuals accounted for part A costs of $657 million in fiscal year 1974 and $945 million in fiscal year 1975.

TABLE 2

Medicare Supplementary Medical Insurance Experience: Fiscal Years 1967-75 (PART B)

Fiscal year	Total cost (millions)	Total number of enrollees (millions)	Cost per enrollee	Percent change in cost per enrollee
1967 (note a)	$1,163	17.8	$ 65.52	-
1968	1,490	18.0	82.60	26.1
1969	1,748	18.8	92.82	12.4
1970	1,896	19.3	98.18	5.8
1971	2,072	19.7	105.37	7.3
1972	2,299	20.0	114.70	8.8
1973	2,454	20.4	120.13	4.7
1974 (note b)	3,256	22.6	143.82	19.7
1975 (note b)	3,993	23.2	171.84	19.5

a/Enrollees had only 6 months in which to meet the calendar year 1966 deductible which could effect the total costs of the part B program for fiscal year 1967. Also, since this was the first year of the program, utilization may have differed from subsequent years and this could have effected total part B costs.

b/Includes data for the disabled and those with chronic kidney disease. These individuals accounted for part B costs of $487 million in fiscal year 1974 and $651 million in fiscal year 1975.

Effect on Costs of Including the Disabled and Those with Chronic Kidney Disease Under Medicare

The Social Security Amendments of 1972 added provisions to the Social Security Act which included coverage under Medicare of individuals under age 65 who had been entitled to social security or railroad retirement disability benefits for 24 months or more, and the coverage of individuals suffering from chronic renal disease if they require regular dialysis treatment or kidney transplantation. The primary effect of this legislative change was to increase the number of people eligible for Medicare.

The disabled and those with chronic kidney disease use part A benefits which cost about the same per person as

those used by Medicare eligibles 65 years of age or older. However, part B benefits cost substantially more per person for the disabled and those with chronic kidney disease than they do for Medicare eligibles 65 years of age or older. The cost of covering the disabled and those with chronic kidney disease amounted to about $1.1 billion in fiscal year 1974 and about $1.6 billion in fiscal year 1975.

Cost of Inpatient General Hospital Care

To determine the factors which have resulted in the large increases in Medicare costs per beneficiary we analyzed the costs of providing care in general hospitals and in nursing homes. General hospital costs accounted for about 70 percent of total Medicare benefit costs and about 96 percent of total part A benefit costs during fiscal year 1975.

The cost of providing inpatient general hospital care for Medicare beneficiaries increased from $2.7 billion in fiscal year 1967 to $10.1 billion in fiscal year 1975. Table 3 gives the cost of providing inpatient hospital care, the number of days of care provided, the cost per day of care, the percent change in this cost, and the economic inflation rate for the fiscal years 1967 through 1975.

TABLE 3

Cost of Inpatient General Hospital Care Under Medicare PART A

Fiscal year	Total cost (millions)	Total days of care (thousands)	Cost per day of care	Percent change in cost per day of care	Economic inflation rate (note a)
1967	$ 2,729	71,245	$ 38.30	-	18.6
1968	3,465	77,712	44.59	16.4	15.1
1969	4,200	81,716	51.40	15.3	14.7
1970	4,662	80,554	57.87	12.6	10.6
1971	5,354	80,553	66.47	14.9	13.2
1972	5,945	80,038	74.28	11.7	9.4
1973	6,505	81,081	80.23	8.0	5.0
1974 (note b)	7,911	89,361	88.53	10.3	6.0
1975 (note b)	10,090	96,441	104.62	18.2	16.4

a/Consumer Price Index for semi-private hospital room charge.

b/Includes data for the disabled and those with chronic kidney disease.

The total cost of providing inpatient hospital care increased about 270 percent from fiscal year 1967 to fiscal year 1975 and the cost per day of care increased about 173 percent. The increased cost per day of care was due primarily to inflation with some of the increase probably due to more extensive types of care being provided in the hospitals. The increase in the cost per day of care accounts for about $6.2 billion of the increase in hospital costs of fiscal year 1975 over those in fiscal year 1967.

The remainder of the increased costs not attributable to inflation is the result of increased utilization of the hospital benefit by Medicare part A eligibles and the increase in the number of eligibles. We analyzed Medicare hospital utilization data to determine the increase in utilization.

Table 4 gives the number of hospital admissions, the admissions per 1,000 eligibles per year, the average length of stay, and the days of care per 1,000 eligibles per year.

TABLE 4

General Hospital Utilization Under Medicare

Fiscal year	Admissions (millions)	Admissions per 1,000 eligibles per year	Average length of stay (days)	Days of care per 1,000 eligibles per year
1967	5.13	269	13.9	3,475
1968	5.47	283	14.2	4,013
1969	5.75	293	14.2	4,159
1970	5.92	297	13.6	4,039
1971	6.24	308	12.9	3,975
1972	6.45	314	12.4	3,888
1973	6.81	326	11.9	3,875
1974 (note a)	7.68	332	11.6	3,868
1975 (note a)	8.29	350	11.6	4,074

a/Includes data for the disabled and those with chronic kidney disease.

Table 4 shows that there has been a 62 percent increase in the number of admissions and a 30 percent increase in the admissions per 1,000 eligibles. However, because of the 16 percent decrease in the average length of stay, there has been an increase of only about 9 percent in the days of care

per 1,000 eligibles provided by Medicare which is the increase in the utilization of the hospital benefit by Medicare eligibles. In other words, the average Medicare eligible used 9 percent more hopital days in fiscal year 1975 than was used in fiscal year 1967. This increased utilization rate accounted for about $315 million of the increases in hospitalization costs between fiscal years 1967 and 1975.

The last major factor explaining the increase in Medicare hospital costs is the increase in the number of eligibles. There were about 4.7 million eligibles more in fiscal year 1975 than in fiscal year 1967. These people accounted for about $870 million in increased costs.

In summary, our analysis of the Medicare hospital data indicates that, of the $7.4 billion increase in the cost of providing hospital benefits, $6.2 billion was due to inflation (and possibly the provision of more extensive services in the hospital), $870 million was due to more people being eligible for Medicare hospital benefits, and $315 million was due to an increase in the use of the hospital benefit by eligibles.

If data for the disabled and those with chronic kidney disease is excluded, the total increase in the costs of providing hospital care to those 65 years of age or older was $6.4 billion. Of this $6.4 billion increase, $5.7 billion was due to inflation, $460 million was due to increased numbers of eligibles and $260 million was due to increased utilization.

Cost of Nursing Home Care

In fiscal year 1968, about 21 million days of nursing home care were provided to Medicare beneficiaries at a cost of more than $341 million. By fiscal year 1975, both the cost and the total days of nursing home care had decreased to about $243 million and 8.6 million days, respectively. Table 5 presents the cost of providing nursing home care, the total days of care provided, the cost per day of care, the percent change in this cost, and the economic inflation rate.

TABLE 5

Cost of Nursing Home Care Under Medicare

Fiscal year	Total cost (millions)	Total days of care	Cost per day of care	Percent change in cost per day of care	Economic inflation rate (note a)
1967 (note b)	$139	9,797,000	$14.19	-	8.0
1968	341	21,050,000	16.20	14.2	7.9
1969	392	20,454,000	19.16	18.3	7.6
1970	277	13,223,000	20.95	9.3	7.3
1971	204	8,592,000	23.74	13.3	7.8
1972	167	6,588,000	25.35	6.8	5.3
1973	180	6,989,000	25.75	1.6	3.6
1974 (note c)	213	8,162,000	26.10	1.4	6.4
1975 (note c)	243	8,617,000	28.20	8.0	13.3

a/Consumer Price Index for all medical services.

b/Benefit only available for 6 months.

c/Includes data for the disabled and those with chronic kidney disease.

The reason for the decrease in utilization of nursing home services under Medicare was a stricter enforcement of the requirement included in the Social Security Act that nursing home services be necessary medically. However, even though total utilization and costs are now lower than they were in fiscal year 1968, the cost per day of care in nursing homes has increased about 99 percent between fiscal years 1967 and 1975. Inflation was primarily responsible for this increase.

We analyzed nursing home utilization data to determine the costs avoided by Medicare because of the decreased utilization. Table 6 gives the number of admissions, admissions per 1,000 eligibles per year, the average length of stay, and the days of care per 1,000 eligibles per year for nursing homes for fiscal year 1968 through 1975.

TABLE 6

Nursing Home Utilization Under Medicare

Fiscal year	Admissions (millions)	Admissions per 1,000 eligibles per year	Average length of stay (days)	Days of care per 1,000 eligibles per year
1968	.45	23	47	1,087
1969	.45	23	45	1,041
1970	.33	16	40	663
1971	.27	13	32	424
1972	.25	12	26	320
1973	.28	13	25	334
1974 (note a)	.30	13	27	353
1975 (note a)	.31	13	28	364

a/Includes data for the disabled and those with chronic kidney disease.

Between fiscal years 1968 and 1975 the number of nursing home admissions decreased 31 percent, the admissions per 1,000 eligibles per year decreased 43 percent, the average length of stay decreased 40 percent, and the days of care provided per 1,000 eligibles per year decreased 66 percent. Thus, the average eligible used 66 percent fewer nursing home days per year in fiscal year 1975 than he did in fiscal year 1968. This decrease in utilization enabled the Medicare program to avoid paying for about 17 million days of nusing home care during fiscal year 1975. This represents, at 1975 prices, about a $479 million cost avoidance. However, because of inflation, Medicare paid $121 million more for the care provided in fiscal year 1975 than this care would have cost in fiscal year 1967.

COST INCREASES IN MEDICAID

Since its inception, the Medicaid program, like Medicare, has experienced a large increase in the cost of providing health care. In fiscal year 1967 the cost of providing Medicaid services was about $2.3 billion. By fiscal year 1975, the cost had risen to approximately $12.1 billion. Table 7 lists the total cost of Medicaid services, the number of people who received Medicaid services, the cost per recipient, and the percent change in cost per recipient for fiscal year 1967 through fiscal year 1975.

TABLE 7

Medicaid Experience: Fiscal Years 1967-75

Fiscal year	Total cost (millions)	Total number of recipients (millions) (note a)	Cost per recipient	Percent change in cost per recipient
1967	$ 2,269	5.2	$436	-
1968	3,538	8.6	411	-5.7
1969	3,988	9.5	420	2.2
1970	4,634	15.0	309	-26.4
1971	5,895	18.2	324	4.8
1972	8,138	20.6	395	21.9
1973	8,714	23.5	371	-6.1
1974	9,756	24.3	401	8.1
1975	12,086	22.5	537	33.9

a/The number of recipients is the number of people who received Medicaid services at some time during the year. Since some people eligible for Medicaid never receive services, the figures given do not represent the number of eligibles.

Table 7 shows that there has been a 433 percent growth in total Medicaid costs, a 333 percent increase in the number of people who received Medicaid services, and that the cost per recipient has increased 23 percent. However, the cost per recipient figures given in the table can be misleading. The number of recipients represents the number of people who, at some time during the year, actually had at least one medical service paid for by Medicaid. These recipients may have been eligible for Medicaid for the entire year or only for 1 month during the year. Also, the number of recipients figure does not give the total number of people eligible for Medicaid because some eligibles never receive a medical service during a particular year. Because of these factors, the cost per recipient is not equal to the cost per year of eligibility, and therefore, is not strictly comparable from year to year. Data to determine cost per year of eligibility is not available in HEW.

The large increase in the number of persons receiving Medicaid services was caused by (1) additional States starting Medicaid programs (in January 1967, 25 States and 3 jurisdictions representing about 75 percent of the Nation's population had Medicaid programs in operation, but by August 1972, 49 States and 4 jurisdictions representing 99 percent of the Nation's population offered Medicaid services); (2) an increase in the number of States covering the

medically needy (in July 1970, 27 States and jurisdictions had Medicaid programs covering the medically needy, but as of July 1975, 32 States and jurisdictions with about 65 percent of the Nation's population covered the medically needy), and (3) an increase in the welfare rolls (about 7.5 million persons were receiving some form of public assistance in 1967 compared to 15.5 million in June 1975).

Because of this increase in Medicaid eligibles, the total number of services used and the total cost of providing those services have increased significantly. For example, table 8 shows that from calendar year 1968 to fiscal year 1974 the total days of care provided to Medicaid recipients in general hospitals has more than doubled and the cost of providing this care rose about 260 percent.

TABLE 8

Cost of Inpatient General Hospital Care Under Medicaid (note a)

Year	Total cost (thousands) (note b)	Total days of care (note b)	Cost per day of care (note b)	Percent change (note b)	Economic inflation rate (note c)
CY 1968	$ 445,406	7,554,432	$59	-	13.6
CY 1969	946,554	11,908,554	79	33.9	13.4
CY 1970	1,412,827	(d)	(d)	-	12.9
FY 1972	2,220,662	22,841,411	97	-	9.4
FY 1973	1,558,137	16,732,238	93	-4.1	5.0
FY 1974	1,605,201	16,556,175	97	4.3	6.0

a/Figures include data for persons under 65 years of age. Most Medicaid eligibles over 65 are also covered by Medicare and Medicaid only pays for the Medicare deductible until Medicare benefits are exhausted. Thus, data for those over 65 was deleted to prevent distortion of the cost data.

b/Because not all States having programs reported data for each year, the figures cannot be accurately compared from year to year. For example, the fiscal year 1972 data includes the information for New York while the fiscal year 1974 data does not.

c/Consumer Price Index for semi-private hospital room charge.

d/Not available.

Because of the difficulty in obtaining comparable data for specific types of services for Medicaid from one year to another, we believe that analysis of the available data would not be meaningful. Therefore, we selected 3 States that had reported data for calendar years 1968 and 1969 and fiscal years 1972 through 1974. We selected California, Michigan, and New Mexico because they represent a large, medium and small State. Using these 3 States' data, we compiled cost data for inpatient general hospital services and nursing home services.

Table 9 presents the experience the 3 States reported having in providing inpatient hospital services to Medicaid recipients and table 10 does the same for nursing home services. California's cost per day of general hospital care increased by 40 percent from calendar year 1968 to fiscal year 1974. During the same period, this cost rose by 77 percent in Michigan and 102 percent in New Mexico. Similarly, California's cost per day of nursing home care increased 32 percent, Michigan's by 48 percent, and New Mexico's by 36 percent. Most of the increases in hospital and nursing home costs per day of care are attributable to inflation.

TABLE 9

General Hospital Costs for the Medicaid Program in Three Selected States
(Recipients Under 65 Years of Age)

	California			Michigan			New Mexico			Economic inflation rate (note a)
Year	Total cost (millions)	Cost per day of care	Percent change	Total cost (millions)	Cost per day of care	Percent change	Total cost (millions)	Cost per day of care	Percent change	
CY 1968	$185.8	$100	-	$ 41.1	$53	-	$3.7	$ 52	-	13.6
CY 1969	230.6	111	11.0	44.8	69	30.2	3.6	58	11.5	13.4
FY 1972	314.3	102	(b)	101.7	91	(b)	5.2	80	(b)	9.4
FY 1973	316.7	114	11.8	135.4	84	-7.7	6.8	99	23.8	5.0
FY 1974	369.5	140	22.8	147.0	94	11.9	7.8	105	6.1	6.0

a/Consumer Price Index for semi-private hospital room charges.

b/Percent changes were not calculated because of the change from calendar year to fiscal year data.

TABLE 10

Nursing Home Costs for the Medicaid Program in Three Selected States

Year	California			Michigan			New Mexico			Economic inflation rate (note a)
	Total cost (millions)	Cost per day of care	Percent change	Total cost (millions)	Cost per day of care	Percent change	Total cost (millions)	Cost per day of care	Percent change	
CY 1968	$165.4	$10.83	-	$ 89.7	$11.67	-	$3.5	$10.63	-	7.3
CY 1969	194.3	11.14	2.9	80.9	15.29	31.0	2.2	12.22	15.0	8.1
FY 1972	227.7	11.14	(b)	116.6	14.99	(b)	1.7	13.97	(b)	5.3
FY 1973	258.5	11.99	7.6	159.8	14.76	-1.5	.8	13.93	-0.3	3.6
FY 1974	305.1	14.26	18.9	130.1	17.22	16.7	.1	14.48	3.9	6.4

a/The inflation rate is for all medical care services not just services provided in nursing homes. The inflation rate is taken from the Consumer Price Index.

b/Percent changes were not calculated because of the change from calendar year to fiscal year data.

Effect on Medicaid of Covering Additional Services

Also contributing to the cost increase in Medicaid have been the actions taken by the States to increase the number of services made available to Medicaid recipients. Some States have added optional services in addition to those that are required. For example, in October 1973 Arkansas, under its Medicaid program, began paying for preseription drugs.

In fiscal year 1974 this additional service cost Arkansas' Medicaid program about $6.3 million. Many other States have also increased the number of services provided under Medicaid and this has increased total program costs.

Conclusions

Inflation and an increase in the number of people eligible for Medicaid benefits are two of the main reasons for the increased costs of the program. Optional coverage of additional benefits also contributed to Medicaid's cost growth. Because of a lack of data on the Medicaid program, we were unable to determine what portion of the increased costs were attributed to each of these factors.

CHAPTER 3

PREVIOUS GAO RECOMMENDATIONS FOR CONTROLLING UNNECESSARY COSTS IN MEDICARE AND MEDICAID

The Chairman requested that we catalog previous recommendations we had made to HEW for controlling unnecessary costs in Medicare and Medicaid. The Chairman specifically wanted us to describe those recommendations which have been fully or partially implemented and to assess the impact those recommendations have had on controlling unnecessary costs of the programs. In addition, the Chairman wanted us to describe those recommendations which HEW has not implemented, assess the current applicability of the recommendations and assess the impact had the recommendations been implemented.

We reviewed prior GAO reports on the Medicare and Medicaid programs to identify GAO recommendations made to HEW for controlling unnecessary costs under the programs. The recommendations identified during our review, actions HEW reported taking in response to those recommendations as of December 1, 1975, and the impact the recommendations had, or would have had if implemented, on the programs are presented in Appendix II for Medicare and Appendix III for Medicaid. Each of these appendixes begins with a summary table.

A review of the implementation of the recommendations made by GAO shows that, of 24 recommendations relating to Medicare, 18 were fully or substantially implemented by HEW, 3 were partially implemented, 3 were not implemented. Two were not implemented because of congressional actions. Of the 59 recommendations relating to Medicaid, 11 were fully or substantially implemented, 44 were partially implemented, and 4 were not implemented. In classifying the recommendations, we counted a recommendation as being partially implemented if HEW had initiated, but not completed, a course of action or if HEW had, in our opinion, taken actions which did not fully comply with the intent of the recommendation.

In most cases, it is difficult to place a monetary value on the results of the implementation of a GAO recommendation or the loss of savings because a recommendation was partially or not implemented. This is because GAO reviews are generally conducted to determine basic weaknesses in program management. All of the costs associated with these weaknesses are not necessarily identified or projected.

However, there were two cases in which HEW has implemented our recommendations and quantified the results. In the first case, we recommended that SSA modify or eliminate the use of the combination method of apportionment for reimbursing hospitals. When SSA did modify the method in 1971, it estimated savings of $100 million a year and these savings should have increased as hospital costs increased. (See pp. 43 to 46.) When SRS established a maximum allowable cost for drugs, it estimated savings of $48 million per year. (See pp. 72 and 73.)

CHAPTER 4

COST CONTROL EFFORTS IN MEDICARE AND MEDICAID

The Chairman requested that we provide information on efforts made by the Congress and by HEW to control the costs of the Medicare and Medicaid programs. The eight areas of interest listed by the Chairman were:

--modifying the reimbursement methods for providers;

--increasing the share of cost borne by program beneficiaries;

--reducing unneeded utilization;

--changing benefits and eligibility for services;

--emphasizing the use of more cost-effective providers;

--improving program management to eliminate fraud and abuse;

--reducing costs for claims processing and program administration; and

--strengthening Federal administrative capacity.

CONGRESSIONAL COST CONTROL EFFORTS

The Congress has enacted two major pieces of legislation affecting the Medicare and Medicaid programs--the 1967 and 1972 amendments to the Social Security Act, P.L. 90-248 and P.L. 92-603, respectively. Each of these acts contained a number of provisions designed to control the costs of the health programs. While a number of other laws also affected the program, as agreed with the Chairman's office, we will only discuss the two major amendments.

The congressional legislative committees responsible for the Medicare and Medicaid programs estimated the savings that would be realized from the changes made in the law. The House Committee on Ways and Means estimated that the provisions of the 1967 amendments would enable avoidance of $1.4 billion in Federal Medicaid funds during fiscal year 1972. The Senate Committee on Finance estimated that the 1972 amendments would enable Federal Medicaid cost avoidances of $108 million in the first year and $193 million in the second year.

A section by section analysis of the 1967 and 1972 amendments is presented in Appendixes IV and V, respectively. The analysis gives what the section provided, implementation status as of December 1, 1975, and the intended impact of the section on costs and, where applicable, providers and beneficiaries.

The section by section analysis shows that HEW was slow in implementing many of the provisions, often taking one or more years after the effective date of the section to implement it by regulation. In fact, even though the 1972 amendments have been law for more than 3 years, several of its provisions have not yet been implemented. Because of these delays in implementation, some of the benefits expected by the Congress in passing the laws have not been realized.

HEW COST CONTROL EFFORTS

HEW has taken action on its own initiative under its administrative powers to control Medicare and Medicaid costs. The following sections outline some of the actions that have been taken.

Medicare

We extracted the major actions taken by HEW from its annual reports 1/ on Medicare which section 1875(b) of the Social Security Act requires to be submitted to the Congress.

The First Annual Report on Medicare describes how HEW initially implemented the Medicare program. The report discusses among other things how the provider reimbursement and utilization review systems were established. The first annual report presents the base for the Medicare program on which subsequent actions were taken. Highlights of administrative actions taken from the other annual reports are presented below.

During fiscal year 1968, HEW issued to its carriers criteria for structuring duplicate claims detection systems

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1/ HEW has submitted seven annual reports on the Medicare program to the Congress each of which have been printed as House Documents. Each annual report covers one fiscal year beginning with 1967 and ending with 1973. The House Document Numbers for the first through the seventh annual reports on Medicare are, respectively, 90-331, 91-57, 92-125, 92-284, 93-36, 93-252, and 94-34.

and establishing a duplicate claims reporting system. Because of the size and complexity of the Medicare part B program, a duplicate claims problem had arisen. Also, to further assist the carriers in their claims processing operations, HEW initiated development of a model computer claims processing system for part B. By the end of fiscal year 1973, 27 carriers were using the model system.

In addition, during fiscal year 1968 HEW assisted its carriers in improving their screening of claims to insure that the claims paid on a reasonable charge basis do not exceed customary and prevailing charges. One measure of the effectiveness of these efforts is the percentage of claims where charge reductions were made. During the first six months of the Medicare part B program, 3.9 percent of the claims had the charges reduced an average of 2.4 percent while during the last 6 months of fiscal year 1968, 6.4 percent of the claims were reduced an average of 3.2 percent. HEW also issued guidelines which established the maximum allowable payments at the 83rd percentile of all charges for similar services submitted on claims. Some carriers had been paying at levels up to the 90th percentile. 1/

By 1974, about 64 percent of physicians and supplier claims had reasonable charge reductions with an average reduction of about 14 percent. Based on 1974 payments for such services of about $2.5 billion, the value of a 10 percent increase in the rate of charge reductions in terms of savings to the program, would be about $180 million. However, because fewer physicians have been accepting the assignment of Medicare claims, 2/ about half of such savings represented charges to the beneficiaries.

1/ Effective January 1, 1971, HEW lowered by regulation the maximum allowable payment level to the 75th percentile of customary charges. Section 224 of P.L. 92-603 limited physician payments to the 75th percentile.

2/ Under part B of Medicare, a physician or supplier claim may be assigned or unassigned. On an assigned claim, the program pays the physician directly and the physician agrees to accept Medicare's reasonable charge as the full charge and the beneficiary is liable only for 20 percent of the reasonable charge. On unassigned claims, the program pays the beneficiary 80 percent of the reasonable charge and the settlement of the full charge is a matter between the beneficiary and the physician. In 1969 about 62 percent of such claims were assigned whereas in 1975 about 52 percent of claims were assigned.

In fiscal year 1969, HEW imposed restrictions on physician fees, the effect of which was to hold physician reimbursements at the existing levels. Guidelines were issued to clarify how physicians in teaching hospitals were to be paid and actions were taken to recover previous overpayments to these physicians. (GAO had reported on this problem. See p. 49.)

During fiscal year 1970, HEW eliminated from its hospital cost reimbursement formula the allowance for provider costs not otherwise specifically recognized--2 percent for nonprofit institutions and 1.5 percent for proprietary institutions. This action reduced hospital reimbursements by about 2 percent. However, most of these savings were offset by allowing a nursing cost differential of 8.5 percent of nursing costs. This differential was allowed because of the reported above average use of routine nursing care by the aged. 1/ The nursing differential increased payments by about 1.2 percent so the net effect of these two changes was a 0.8 percent reduction in payments to hospitals.

Fiscal year 1970 was also the first full year of SSA's program to assign resident representatives to its contractors. SSA believes that this program has been highly beneficial for Medicare and greatly assists in program management.

SSA also established in fiscal year 1970, as a permanent part of its Medicare management organization, a Program Integrity Unit. Each SSA regional office, as well as SSA headquarters, has one of these units. Carriers and intermediaries are also contractually required to have program integrity units.

With respect to reimbursement to institutional providers, such as hospitals and nursing homes, regulation changes were published in August 1970 that reduced the possibility of excessive reimbursement through the use of accelerated methods of depreciation and reduced the possibility of inflated valuation of assets in determining the basis for reimbursement for depreciation, return on

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1/ In 1975, HEW attempted to eliminate the 8.5 percent nursing differential. However, a Federal court decision prevented the elimination of the differential.

equity and interest expense. 1/ Also, during 1971, SSA placed emphasis on the "prudent buyer" concept for identifying and disallowing, during audit, the unreasonable costs incurred by institutions in purchasing supplies and services.

Activities during fiscal year 1971 included initiation of the development of two model claims processing systems for part A. One system was completed in fiscal year 1971 and the other in fiscal year 1972. By the end of fiscal year 1973, 17 intermediaries were using these systems which are designed to provide faster, more efficient computer processing of claims.

To help control the costs of the Medicare program, HEW, during fiscal year 1972, urged Medicare carriers and intermediaries to minimize their bank accounts. During the next two years bank balances were reduced about $64 million with estimated annual interest savings of about $4.1 million.

HEW also issued regulations which prohibited the use of the combination method of cost apportionment by institutions with more than 100 beds, required its use for smaller institutions, and eliminated certain non-Medicare related costs (for example, delivery room costs) from the combination method. These actions resulted in estimated annual savings of about $100 million. (GAO had recommended the elimination or modification of the combination method. See p. 45.) Also, in line with GAO findings, SSA issued instructions to its paying agents to assure that retroactive adjustments were made to recover excessive payments to hospitals for the services of hospital-based physicians.

During fiscal year 1973, most of HEW's efforts relating to Medicare were aimed at implementing the provisions of the 1972 amendments to the Social Security Act. However, in May 1973, HEW eliminated Medicare's current financing--advance payments to institutional providers. This action resulted in a one time cash outlay savings of about $300 million and an annual interest expense savings of about $20 million.

1/ A discussion of GAO's views on the need for changes in allowable depreciation methods is contained in a report to the Chairman, Senate Committee on Finance, entitled "Payments to Hospitals and Extended Care Facilities For Depreciation Expense Under the Medicare Program," B-142983, August 21, 1970.

Overview of HEW's Medicare Cost Control Efforts

When viewed on historical perspective, the effects of HEW's cost control efforts appear to be susceptible to some quantifiable measurement in the following areas:

1. Modifications of formula for reimbursing institutional providers

Modifications to the reasonable cost reimbursement formula through the reduction of the so-called plus factors from 2 to 1.2 percent of total costs and the changes in the use of the combination method of apportionment could have had the effect of reducing reimbursement to institutional providers by as much as 3 or 4 percent. Other cost control improvements in the cost reimbursement regulations and guidelines such as the limitations on use of accelerated depreciation and the emphasis placed on the "prudent buyer" concept which were designed to curb program participation in real or perceived unreasonable costs are not readily susceptible to quantifiable measurement.

In any event, whatever reductions have been effected have been relatively minor when compared with the inflationary increases in inpatient hospital costs of about 170 percent.

2. Modification to reasonable charges reimbursement formula

Changes in the methodology for paying physicians and suppliers on the basis of reasonable charges under part B consisted of actions such as the implementation of customary and prevailing charge screens at the carriers and the reductions in the overall fee limitations (prevailing charges) from the 90th percentile to the 75th percentile of customary charges. Such modifications resulted in increasing the rate of reduction of submitted charges from about 3 percent to 14 percent. A substantial portion of such reductions, however, have been passed on to the beneficiaries.

3. Reducing unneeded utilization of hospital and nursing home services

Since 1968 the average length of stay in hospitals and skilled nursing facilities under Medicare has decreased. The extent to which such decreases have been due to improvements in provider utilization review activities, improvements in the intermediaries' claims processing and utilization screens, or changes in the practice of medicine is not

known. Nevertheless, if the average length of stay in hospitals and skilled nursing facilities in 1975 was the same as it was in 1968, the costs under part A would have been about $2.4 billion more than the costs actually were.

Medicaid

SRS officials told us that a number of administrative changes and improvements had been made in the Medicaid program since its inception. They provided details on the four actions which they felt were most significant and these follow.

Hospital Reimbursement Methods

In July 1971, SRS allowed, through regulations, States to develop hospital reimbursement methods of their own on an experimental or demonstration project basis instead of requiring the use of the Medicare method. Alternative methods were subject to the approval of the Secretary before they could be used. Section 232 of the Social Security Amendments of 1972 established in law a provision allowing States to use alternative methods for reimbursing hospitals. Four States have received approval for an alternative method.

Measuring Effectiveness of Utilization Controls

Because of the difficulty in identifying whether costs are avoided directly as a result of utilization controls, SRS has contracted for the development of a methodology to assist in identifying the "Impact of Utilization Controls." SRS officials said that an extremely crude "first cut" analysis of three States has been completed. Although the contractor is optimistic that the methodology developed will enable the States to estimate costs avoided by utilization control and that the preliminary findings on the three States in the study will be conclusive, the SRS project officer is more skeptical. A better assessment of this contract effort will not be possible until early 1976.

Use of Prepaid Health Plans

SRS officials told us that the ultimate cost-effectiveness of HMO-type providers has not yet been fully determined. In their opinion, the most definitive study so far to determine the cost-effectiveness, while maintaining quality of care, is the Westat evaluation, funded by SRS, of a 3-year demonstration in the District of Columbia in

which approximately 1,000 Medicaid recipients were enrolled in Group Health Association. Before and after comparisons of both cost and utilization were made; average savings of 21 percent for the 3-year period, in comparison to the fee-for-service costs, were indicated. Group Health Cooperative of Puget Sound has reported similar savings for its Medicaid enrollees.

The SRS officials said that, in order to assist States to contract with and effectively monitor HMO-type Medicaid providers, SRS has initiated the following activities:

1. Final regulations (45 CFR 249.82) were published on May 9, 1975. Significantly strengthened quality and cost standards were incorporated. Several of these were added in direct response to the GAO recommendations, resulting from its 1974 report on prepaid health plans in California. (See p. 87.)

2. Draft guidelines to assist States to implement these regulations are presently being circulated within HEW, both in the central office and in the regions.

3. Technical and actuarial assistance has been provided to eight States (California, Hawaii, Connecticut, New York, Maryland, Louisiana, New Jersey, Massachusetts), to enable them to implement sound rate-setting systems. Assistance to Pennsylvania has been approved, and negotiations are in process with Ohio, Illinois and Wisconsin.

4. A California proposal for a demonstration, under the prospective reimbursement authority of section 222 of P.L. 92-603, is presently under review. The demonstration should reult in the development of a model State cost and quality assessment system for HMO-type providers. The development of such a system was recommended by GAO in its 1974 prepaid health plan report. (See p. 90.)

SRS officials also said that, as an alternative to the current reimbursement on a reasonable cost basis, SRS is cooperating with SSA in an experiment on hospital prospective reimbursement under section 222. The grantee is

the University of South Carolina for the research component. SRS has granted a title XIX waiver so that the hospitals involved in the experiment can be reimbursed according to the same formula under Medicaid as under Medicare.

We requested SRS to estimate the savings that have accrued because of cost control actions taken by the agency. SRS officials replied that there was no way to estimate total savings due to cost avoidance. They said that the focus of management has been, and remains, a continuous effort to improve the quality and delivery of medical care services and to minimize unnecessary or lengthy procedures or hospital stays. SRS believes that continuous management improvement in this area should reflect an annual 5-10 percent reduction in expenditures, at least in the first few years. After that, if unnecessary services have been substantially reduced, it would be difficult to continue to reflect annual savings of that magnitude.

The officials said that Medicaid expenditures have risen continuously due to increased numbers of eligibles, a slight increase in utilization, and ever increasing cost escalation. Thus, savings would be impossible to quantify in the light of the sharply rising overall Medicaid expenditures. As a result, SRS could not estimate the cost avoidance savings and believes it is unlikely that savings could be estimated accurately even if better data were routinely available.

HEW Experimental and Demonstration Projects

Section 402 of the Social Security Amendments of 1967 (P.L. 90-248) authorized the Secretary of HEW to conduct experiments to test the effectiveness of incentives in reducing or retarding increasing program costs without adversely affecting the quality of care. The provisions of sections 222 and 245 of the Social Security Amendments of 1972 (P.L. 92-603) expanded the areas of experimentation in health care financing. Among the authorized areas are: (1) prospective reimbursement 1/ (including negotiated rate

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1/ Section 222 of P.L. 92-603 required the Secretary to develop and carry out experimental and demonstration projects on prospective reimbursement. The Secretary was required to report to the Congress by July 1, 1974, on the results of these experiments and demonstration projects. This reporting deadline was missed and HEW expects to submit the report by January 1977.

and State rate setting); (2) incentive reimbursement; (3) non-covered services, including ambulatory surgery; (4) intermediate care homemaker services, day care services; (5) physician extender services; (6) physician reimbursement; and (7) durable medical equipment.

HEW is currently funding or developing experimental and demonstration projects in all of the areas authorized by the law. Since the projects are ongoing, complete results are not available and the projects have not been fully evaluated. SSA expects that an analysis and evaluation of its perspective reimbursement projects will be completed by January 1977. A description of some of SSA's projects follows.

Hospital Prospective Reimbursement Experimentation-University of South Carolina

The University of South Carolina and the Social Security Administration have signed a contract ($1,400,000) for a 3-1/4 year (October 1, 1974, to January 31, 1978) prospective rate experiment involving approximately 25 percent of the short-term hospitals in the State of South Carolina. This prospective rate project combines budget review, management engineering, and financial planning in a single system which is intended to reduce or contain hospital costs. The basic premise of the project is that a hospital can be encouraged through the use of management engineering techniques to implement cost savings programs if the resulting savings can be used by the hospital to help finance planned new capital expenditures.

Long-term Care Reimbursement - the Utah Cost Improvement Project

The Utah State Division of Health and the Social Security Administration have joined in this 3-year experiment (which began January 1, 1973) in which 16 rural Utah hospitals are participating. Each of these hospitals has less than 100 acute beds, a chronic low occupancy rate (less than 60 percent) and is located in an area where skilled nursing facilities are not available.

The Utah experiment is designed to test a reimbursement formula which would reduce a hospital's acute care cost while alleviating two problems prevalent in many rural communities: low occupancy rates in community hospitals and a shortage of long-term beds. The efficient use of a hospital's existing resources is emphasized in trying to solve these problems.

Important side benefits are expected to be better continuity of care (since the patient can receive both acute and long-term care in the same institution), a reduction in travel (since the patient can receive his long-term care locally), and conservation of capital expenditures (since few, if any, free-standing long-term facilities need to be built).

Incentive Reimbursement - Birmingham

This 3-year Group Reimbursement Incentive Experiment which terminates in December 1975, is designed to achieve cost containment by reducing the rate of increase in costs of the participating hospitals. To achieve this primary goal, costs of the 22 hospitals participating in the experiment are projected by use of a statistical regression model, mutually acceptable in the Birmingham Regional Hospital Council and SSA. At the end of each fiscal year, the actual cost performance of all the hospitals as a group is compared to the projected composite performance for that year.

Incentives are expressed as a percentage of the savings calculated between the hospitals' actual costs and those projected by the regression model. No incentives can be paid to any hospital, however, unless the total cost of all hospitals participating in the experiment is below that projected for the group. A single incentive payment would be given for distribution to the group of participating hospitals according to an agreed on formula.

During the first year, cost containment efforts were directed toward establishing group purchasing arrangements, promoting improved management techniques and identifying high cost departments so that appropriate steps could be taken to reduce these costs.

The evaluation of the project in Birmingham is being performed by the Health Systems Research Center of the Georgia Institute of Technology in Atlanta, under a contract with SSA that began in March 1973 and will continue through 1976.

CHAPTER 5

POSSIBLE FURTHER CONGRESSIONAL EFFORTS TO CONTROL MEDICARE AND MEDICAID COSTS

The Chairman requested that we make proposals for further legislative and/or administrative actions to reduce the rate of increase in Medicare and Medicare costs. As far as administrative actions are concerned, we can only propose at this time that HEW fully implement the recommendations we have already made and classified in this report as partially or not implemented. Without performing additional reviews, we are not in a position at this time to make additional recommendations.

We understand that the Chairman, Subcommittee on Health, Senate Committee on Finance, plans to introduce a bill containing a number of provisions designed to control the costs of the Medicare and Medicaid programs (see S11122 through 11125, Cong. Rec. June 20, 1975). Many of the proposals outlined by the Chairman are consistent with findings and recommendations that have been made by GAO.

SUGGESTED LEGISLATIVE ACTIONS

There are two legislative actions which we believe the Congress should take based on our prior reports. One relates to reimbursements for durable medical equipment and the other to the use by the Railroad Retirement Board of a separate carrier to pay for part B services provided to its beneficiaries. Details follow.

Durable Medical Equipment

On May 12, 1972, GAO issued a report to the Congress entitled "Need for Legislation to Authorize More Economical Ways of Providing Durable Medical Equipment Under Medicare." In that report we discussed how Medicare patients often rented durable medical equipment even when the periods of need, as estimated by their physicians, were long enough to justify purchase.

During GAO's review at five carriers in four States, GAO analyzed a statistical sample of patients' claims selected from the claims of the 13,000 patients whose claims for durable medical equipment were processed in 1970. For the 13,000 patients, GAO estimated that savings of $234,000--including the patients' share of $47,000--could have been

realized if the equipment had been purchased when the anticipated periods of need indicated that purchases would have been more economical than rentals.

At a sixth carrier in the fifth State, GAO analyzed a sample selected from the claims of the 7,000 patients whose claims were processed during August 1971. For the 7,000 patients, GAO estimated that savings of $763,000--including the patients' share of $153,000--could have been realized.

In the report, GAO recommended, that the Congresss amend the Medicare law to authorize HEW to find more economical methods for paying for durable medical equipment including authority to:

--Make lump-sum payments for purchases of equipment when, on the basis of anticipated periods of need, purchase appears to be more economical than rental; require the early submission of such claims; and limit payments to the amounts payable under the recommended rent-or-purchase decision.

--Enter into agreements with suppliers aimed at limiting rental payments after they exceed the purchase prices by specified percentages and at obtaining prices for the purchase of equipment that are comparable to those obtained by other federally financed health programs.

In line with this recommendation section 245 of P.L. 92-603 authorized the Secretary to conduct experiments designed to eliminate unreasonable expenses resulting from prolonged rentals of durable medical equipment including purchase if justified by the anticipated length of rental. The Secretary was also authorized to implement on a nationwide basis any reimbursement procedures developed in these experiments. HEW issued a request for proposals for such experiments in December 1973 and one of the items in the request was lease-purchase agreements. As of December 1975, no contract awards had been made to study lease-purchase agreements.

We believe that our report demonstrated the economic benefits available from the use of lease-purchase agreements for durable medical equipment. A bill, H.R. 8717, introduced on July 17, 1975, would require the Secretary to enter into lease-purchase agreements with suppliers and to encourage the use of lease-purchase agreements for durable medical equipment. We recommend that the Congress enact H.R. 8717.

Railroad Retirement Board Medicare Claims Processing Contracts

In our report entitled "Opportunity to Reduce Medicare Costs by Consolidating Claims Processing Activities," B-164031(4), January 21, 1971 (see p. 41), we discussed the unnecessary expenditure of administrative funds caused by the Railroad Retirement Board contracting for the processing of Medicare claims for railroad beneficiaries. Since railroad beneficiaries only represented about 4 percent of total Medicare beneficiaries, we questioned the use of a separate carrier for these beneficiaries. We estimated that $2.8 million in administrative costs could be saved if the railroad beneficiary claims were processed by the carriers used by SSA. Therefore, we recommended that SSA withdraw its delegation of authority to contract from the Railroad Retirement Board and arrange to have railroad beneficiaries' claims processed by the carriers handling all other Medicare beneficiary claims.

However, the Congress subsequently enacted a law (section 263(d)(5) of P.L. 92-603) which gave the Railroad Retirement Board the authority to contract with carriers. Therefore, SSA could not implement our recommendation.

The use of a separate carrier to process and pay claims for a special, small group of beneficiaries seems inherently duplicative in administrative costs and we suggest that the Congress consider repealing the law authorizing the Railroad Retirement Board to contract with carriers.

APPENDIX I

NINETY-FOURTH CONGRESS

U.S. House of Representatives
COMMITTEE ON THE BUDGET
Washington, D.C. 20515

August 5, 1975

The Honorable Elmer B. Staats
Comptroller General of the United States
General Accounting Office
441 G Street
Washington, D.C. 20548

Dear Mr. Staats:

The Committee on the Budget of the House of Representatives has established a group of task forces to examine the major Federal program areas in anticipation of both the second budget resolution for FY 1976 in the fall of this year and the first budget resolution for FY 1977 in the spring of next year. I am chairman of the Human Resources Task Force.

One of the issues we are concerned with is the size and growth of Federal expenditures in the Medicare and Medicaid programs. Medicare and Medicaid are estimated to spend almost $25 billion in 1976, an increase of over $3 billion over 1975. The rapid escalation in spending in these two programs is making it extremely difficult to mount new health initiatives and is giving the public and Congress concern about the future cost impact of national health insurance.

I know that over the years these two programs have also occupied a good deal of your staff time and attention. It would be helpful at this time if you would review your assessments and recommendations which have had an impact on Medicare and Medicaid costs or would have an impact if fully adopted. In addition, I would like to have your staff catalog and assess the major cost control efforts undertaken by the Department of HEW through administrative action and by the Congress through legislative action. Finally, based on your experience and expertise with these programs, it would be useful to us to have your proposals for action that could be taken through either administrative or legislative processes to control unnecessary program costs in the future, and their potential impact on the various participants in these two programs -- the providers and practitioners of health care, the beneficiaries, the States and the Federal government.

APPENDIX I

Attached is an outline specifying the scope and content of the review I would like to have done. I would appreciate completion of the project by October 15, 1975. Mr. Joseph Manes of the staff of the Budget Committee is available to serve as liaison with your staff and provide assistance on specific problems and questions. He can be reached at 225-7244.

Sincerely yours,

Parren J. Mitchell
Member of Congress

PJM/JM/gsr

Cost Controls in Medicare and Medicaid

I. Impact of medical care prices on Medicare and Medicaid expenditures

A. History of medical care price changes since the enactment of the Medicare and Medicaid programs (1966)

B. Calculation of portion of Medicare-Medicaid expenditures attributable to price increase

C. Factors in Medicare-Medicaid contributing to cost escalation

II. Catalog of previous GAO recommendations for controlling unnecessary costs in Medicare and Medicaid

A. Description of recommendations which have been fully implemented
--assessment of impact

B. Description of recommendations which have been partially implemented
--assessment of impact

C. Description of recommendations which Department of HEW has not implemented

1. assessment of current applicability of recommendation
2. assessment of impact if implemented

III. HEW and Congressional Efforts at Cost Control in Medicare and Medicaid

A. History of efforts to control costs by:

1. Modifying formula for reimbursing providers and practitioners
2. Increasing share of cost borne by beneficiaries
3. Reducing unneeded utilization of hospital nursing home and physician services
4. Changing benefits and eligibility for service
5. Emphasizing use of more cost-effective providers (e.g., HMO)
6. Improving management to eliminate fraud, duplicate payments, etc.
7. Reducing costs for processing claims and overall program administration
8. Strengthening Federal administrative capacities

B. Assessment of effectiveness of efforts to control costs

1. Estimate of costs avoided through successful cost control efforts
2. Assessment of HEW implementation of Congressional legislative directives
3. Impact on providers, practitioners, beneficiaries and States

C. Description and assessment of experiments and demonstration projects in prospective reimbursement and incentives to economy

IV. Proposals for further legislative and/or administrative action to reduce rate of increase in Medicare and Medicaid costs

A. Description of proposals (In same sequence as II. A. above)

B. Impacts on Federal budget, program beneficiaries, States, providers and practitioners

STATUS AS OF DECEMBER 1, 1975, OF

IMPLEMENTATION OF SELECTED GAO RECOMMENDATIONS

TO CONTROL UNNECESSARY MEDICARE COSTS

Summary Table

Purpose of recommendation	Recommendation number a/			
	Fully or substantially implemented	Partially implemented	Not implemented	Not implemented because of congressional action
Modify method of reimbursing providers	A-2, C-1	None	None	E-1
Increase share of costs borne by beneficiary	None	None	None	None
Reduce unneeded utilization	D-1, D-2, D-3, D-4, F-1	F-3	None	None
Change benefits or eligibility criteria	None	None	None	None
Emphasize use of more cost effective providers	None	None	None	None
Improve management to control overpayments, abuses, and fraud	A-4, G-1 G-2, J-1	F-2, J-2	J-3	None
Reduce administrative costs	A-3	None	None	B-1
Strengthen Federal administration	A-1, H-1, I-1, I-2	None	None	None
Other	C-2, C-3	None	None	None

a/The letter indicates the report and the number indicates the recommendation.

Title: A. Improvements Needed in Processing Medicare Claims for Physicians' Services in Texas, B-164031(4), December 31, 1970

Findings: Our review of a random sample of Medicare claims processed by Texas Blue Shield during a 3-month period in calendar year 1967 showed that:

--Payments were made in excess of the charges established by Texas Blue Shield as reasonable for the services.

--Duplicate payments were made.

--Payments were made without obtaining adequate evidence that the charges were reasonable. That was due, in part, to the latitude of judgment a carrier could exercise in making reasonable-charge determinations.

--Errors were made in coding and recording customary-charge data. These errors contributed to improper payments.

Our review showed also that Texas Blue Shield had not implemented appropriate safeguards, contrary to the requirements of its contract with the Secretary of HEW, against payments for unnecessary medical services.

During the period June 1966 through January 1968, Texas Blue Shield entered into a series of subcontracts for electronic data processing services without obtaining the required prior approval from the Secretary of HEW. The subcontracts did not have the required access-to-records clause giving the Secretary of HEW

HEW and GAO the right to examine pertinent books and records of the subcontractor. Since HEW did not have access to those records, the Social Security Administration was committed to making payments that could have amounted to as much as $6 million without having contractual authority to review the pertinent cost records to determine the reasonableness of the subcontractor's charges.

SSA and Texas Blue Shield did not agree on whether prior approval of the subcontracts or the access-to-records clause was mandatory. GAO believes that such questions could have been resolved promptly if the language of the dispute clause included in the carriers' contracts with the Secretary of HEW had been broad enough to cover these kinds of disagreements.

Recommendations: Fully or Substantially Implemented

(1) More effective surveillance by the Social Security Administration of carriers' claims-processing activities.

Several procedures have been implemented by SSA to reduce the costs for claims processing. These procedures were:

--an analysis of all automated system changes to determine if the change was necessary and if so, the best method for making such change; and

--a review and evaluation of all contractors' systems by SSA representatives.

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In addition, a systems technician was placed in Bureau of Health Insurance regional offices. These technicians assist onsite representatives and other regional office staff in evaluating on an ongoing basis carriers' claims and data processing systems, as well as any changes that may be contemplated.

The above techniques for the surveillance of carrier activities are in addition to contract performance reviews by specially trained SSA teams; audits by the HEW Audit Agency, quantitative standards, and required periodic reports from carriers to measure performance; introduction of test claims into carrier systems; and other surveillance measures.

(2) Review and evaluate SSA's current regulations, which allow carriers to make certain assumptions concerning the nature and extent of services provided, to determine how much latitude the carriers should have in determining the reasonableness of charges.

HEW stated that it had reviewed and reassessed its instructions to make sure they do not leave undue room for carrier interpretation.

(3) Clarification of the circumstances under which prior approval by SSA is required for subcontracts awarded by Medicare carriers.

In order to provide for more effective management and cost control of carrier (and intermediary) subcontracts, SSA negotiated revisions to the applicable provisions of its agreements with carriers (and intermediaries). The revisions negotiated require the contractors to submit for review and approval those subcontracts involving

a major function or substantial Medicare funds, particularly those involving electronic data processing, audit or management consultation.

(4) An evaluation by SSA of the effectiveness of the corrective action taken or planned by Texas Blue Shield to improve claims processing detect duplicate claims, and minimize payments for unnecssary medical services.

To prevent payments of claims in excess of reasonable charges, the carrier has eliminated tolerances in making reasonable change determinations. It has also given additional training to the coding staff which is responsible for inputting the basic data on which reasonable charge determinations are made, and has set up a quality control system. To prevent paying claims without proper documentation, the carrier now requires identification of all services prior to payment.

SSA believes that the carrier now has a satisfactory method for duplicate claim detection. The Texas Blue Shield automated dupicate claim detection screen consists of: claim number, date of service, supplier/doctor number, and type of service. Any claim for services failing these edits is identified as a possible duplicate and routed to a specialized group in the Suspense and Reentry Unit for a clerical examination and a positive determination of whether it is a duplicate. As a part of this process, the computer identifies the other claims suspected as being involved in the duplicate. As indicated above, steps also have been taken to control coding errors, thus minimizing the chance of duplicates passing undetected.

Texas Blue Shield is now employing a system of automated utilization

screens. The screens identify physicians who exceed established parameters. These parameters relate to such items as an unusual incidence of performance of particular procedures, of services per patient, of total payment per patient, and of total medical reimbursement. The screens also identify instances where a questionable number of different physicians bill for services to a particular beneficiary in a quarter. Billings identified by these screens are subjected to special scrutiny to ensure that medical services are not being unnecessarily utilized. The agency also has improved its guidelines and training for claims processors.

To ensure that all carriers have effective controls to prevent over-utilization of medical services, HEW issued instructions in February 1970 (Part B Intermediary Letter 70-5) that set out specific prepayment and post-payment controls which must be built into each carrier's system as a bare minimum. Carriers were required to report on the status of any action needed to assure that effective utilization safeguards are part of their ongoing claims process.

Title: B. Opportunity to Reduce Medicare Costs by Consolidating Claims-Processing Activities, B-164031(4), January 21, 1971

Findings: SSA carriers do not make Medicare payments on behalf of eligible railroad workers and annuitants of the Railroad Retirement Board. The Board, under a delegation of authority from SSA, contracted with the Travelers Insurance Company

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to make these payments for about 810,000, or approximately 4 percent, of the 18.9 million people eligible to receive Medicare benefit payments for physicians' services as of January 1, 1969.

Because of the relatively small number of railroad workers and annuitants eligible for Medicare and because certain administrative functions of Travelers appeared to duplicate those of the other SSA carriers, GAO questioned whether the use of a separate carrier to make payments for these beneficairies was the most efficient, effective, and economical way to administer the program.

GAO estimated that benefit payments by Travelers were about $2.9 million higher than the payments that would have been made by the SSA carriers for like medical services in fiscal year 1970.

The use of a separate carrier to process the claims of railroad workers and annuitants also results in increased administrative costs. GAO's comparison of the estimated incremental costs that would be incurred by four SSA carriers making payments in nine States with the administrative costs incurred by Travelers showed that these carriers could process the railroad-related claims for $321,600 a year less than could Travelers. GAO believes that similar savings in administrative costs could be achieved at other locations.

If the estimates for the four SSA carriers are representative

on a nationwide basis, administrative costs of as much as $2.8 million could be saved. These savings would accrue to the beneficiaries and the Federal Government, which shared equally in financing the program.

Recommendations: Not Implemented Because of Congressional Action

(1) HEW should arrange to have the railroad-related Medicare claims paid by the carriers paying such claims for all other Medicare beneficiaries in the same geographical area.

Subsequent to issuance of this GAO report, Congress passed legislation which gave the Railroad Retirement Board the authority to contract with carriers of its choice for the purpose of servicing its beneficiaries with respect to Part B benefits.

It is our opinion that the existing arrangement under which a separate carrier makes benefit payments on a nationwide basis on behalf of a relatively small, special group of Medicare beneficiaries is unnecessarily duplicative. (See p. 31.)

Title: C. Lenghty Delays in Settling the Costs of Health Services Furnished Under Medicare, B-164031(4), June 23, 1971

Findings: Payments to institutions for their costs of furnishing services to Medicare patients are made initially on an estimated basis but are subject to adjustments at the end of the institutions' Medicare reporting periods, after the intermediaries have determined the institution's

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actual and reasonable Medicare-related costs. This procedure culminates in a final settlement between the intermediary and the institution and is referred to as the settlement process.

Because of the lengthy delays by fiscal intermediaries in completing the settlement process, billions of dollars of Medicare funds paid out on the basis of the estimated cost of services long since incurred have not been afforded an appropriate final accounting or a timely review by the intermediaries and the Federal Government.

At September 30, 1970, over 3 years after the end of the reporting periods for the first year under Medicare, final settlements for the cost of care provided had been made with only 68 percent of the hospitals included in the GAO review. Furthermore, at that date, over 2 years after the end of the reporting perioids for the second year under Medicare final settlements for the cost of care provided had been made with only 38 percent of the hospitals included in the GAO review.

There were delays in every step of the settlement process, from the preparation of cost reports by hospitals, through the audit of cost reports by intermediaries, to the final settlement or agreement with hospitals concerning their actual and reasonable Medicare costs to be reimbursed under the program.

Some intermediaries delayed making final settlements with hospitals because a method of apportioning hospital costs between Medicare and non-Medicare patients which was authorized by HEW resulted in Medicare payments that included certain private room costs, which were not covered under the program, and certain delivery room costs,

which were not applicable to Medicare patients. On the basis of an analysis of a sample of cost reports for hospitals in 32 States and Puerto Rico, GAO believes that the elimination of this questionable apportionment method (combination method) would reduce Medicare payments to hospitals by between $100 million and $200 million annually.

Recommendations: Fully or Substantially Implemented

(1) Discontinue or modify the use of the combination method of apportioning hospital costs between Medicare and non-Medicare patients.

HEW discontinued on December 31, 1971, the use of the combination method of reimbursement for hospitals having more than 100 beds. HEW also required smaller hospitals to use the combination method but eliminated from this method certain costs not related to Medicare such as delivery room costs.

HEW estimated that the actions taken in response to GAO's recommendation would save $100 million during fiscal year 1972.

(2) Require the Blue Cross Association to take a more active role in the final settlement process by directly assisting those local Blue Cross Plans that have the most serious backlogs of audited cost reports for which settlements have not been made.

The Blue Cross Association assisted local Blue Cross Plans that had the most serious problems with final settlement backlogs. For example, Chicago Blue Cross personnel were assigned to help the Los Angeles and Indiana Plans to reduce their settlement backlogs.

The assistance given by the Blue Cross Association to local Blue Cross Plans in reaching final settlements with Medicare institutions should result in the final settlement of substantial amounts of Medicare funds.

(3) Establish a definite timetable for the development of effective, useful, and timely reimbursement reports for use by hospitals and intermediaries in the settlement process or consider other alternatives, such as authorizing intermediaries to prepare the reports.

SSA now authorizes its fiscal intermediaries to prepare reimbursement reports for use by hospitals and intermediaries in the settlement process.

Title: D. Improved Controls Needed Over Extent of Care Provided by Hospitals and Other Facilities to Medicare Patients, B-164031(4), July 30, 1971

Findings: GAO found that utilization review committees helped, to some extent, to reduce unnecessary costs which would otherwise have been borne by the Medicare program. However, efforts of SSA and the intermediaries had not resulted in a full understanding, on the part of utilization review committees, of the limitations on the type of care which could be provided and paid for under the Medicare program. GAO's consulting physicians reviewed the same records--for 1,735 Medicare patients--which had been available for examination by the review committees. In 465 cases GAO's consulting physicians questioned whether the care provided should have been paid for under the Medicare program. All of these cases involved extended stays in hospitals and skilled nursing facilities. A need existed for SSA to develop clearer and more definite guidelines pertaining to the responsibilities of State agencies and intermediaries, to insure compliance with the

legislative requirements for utilization reviews and physicians' certifications. SSA also should expand its reviews of State agency activities, to obtain greater assurance that these agencies are enforcing compliance by hospitals and extended-care facilities with their approved utilization review plans.

Recommendations: Fully or Substantially Implemented

GAO made four recommendations in this report, all of which were designed to improve the utilization review process. The recommendations were:

(1) Define more clearly the role of the utilization review committees, to make clear that their decisions are essential to the intermediaries in determining whether the care provided to patients in hospitals and extended-care facilities is covered under the Medicare program.

(2) Define the responsibilities of State agencies and intermediaries more clearly with respect to (1) monitoring follow-through actions taken on the questions raised by review committees and (2) ensuring compliance with the legislative requirements regarding review committees' activities and physicians' certifications and recertifications of the necessity for continued care.

(3) Establish more appropriate criteria for determining when cases involving stays in hospitals and extended care facilities should be reviewed by review committees.

(4) Provide for increased attention, in SSA's reviews, to whether State agencies are doing an adequate job of determining the degree of compliance by hospitals and extended-care facilities with their approved review plans.

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HEW took a number of actions to implement these recommendations. HEW initiated training programs in utilization review and provided instructional material to intermediaries, State agencies, and providers to assist them in carrying out their utilization review responsibilities. Contracts with intermediaries were modified to emphasize their utilization review functions. HEW developed a report issued semi-annually which provides comparative data on the effectiveness of utilization review at different facilties. The data in these reports can be used to help hospitals assess and improve their utilization practices. A number of other actions were also taken.

Because of the actions taken by HEW, there is now more assurance that Medicare is paying only for care in institutions which is really needed by the beneficiaries. One indication of the effectiveness of the improved utilization review program is the reduction in the average length of stay in hospitals and skilled nursing homes that has occurred. The average length of stay in hospitals during fiscal year 1971 was 12.9 days, but by fiscal year 1975 it had been reduced to 11.6 days. Since there were about 8.3 million hospital admissions in fiscal year 1975, the reduction in the average length of stay saved Medicare the cost for about 10.8 million days of care. The average cost per day in 1975 was $104.62 so by saving the 10.8 million days of care, Medicare costs of about $1.1 billion were avoided. During the same period, the average length of stay in skilled nursing facilities decreased 4 days. Since there were about 310,000 admissions in fiscal year 1975, the reduction in the average length of stay saved Medicare from paying for about 1.2 million days of care. At the fiscal year 1975 average cost per day of $28.20, the reduced length of stay saved Medicare about $35 million.

Title: E. Problems in Paying for Services of Supervisory and Teaching Physicians in Hospitals Under Medicare, B-164031(4), November 17, 1971

Findings: Our review of six hospitals' records showed that teaching physicians' services to individual patients paid under part B had, in many instances, been provided only by residents and interns whose salaries were reimbursable as hospital services under part A. If reimbursement for the same services was made under part A and B, Medicare would be paying for such services twice.

The medical records reviewed showed that

--physicians named on the bills had been involved in providing about 18 percent of the number of services billed in their names,

--supervisory physicians, other than the physicians named on the bills, had been involved in providing about 15 percent of the services, and

--residents and/or interns only had provided the remaining 67 percent of the services without any evidence of the involvement of a supervisory physician.

In about 45 percent of the cases where a supervisory physician was identified with a specific service billed to Medicare, the name of the supervisory physician shown on the medical records was different from the supervisory physician in whose name the service was billed. It was difficult, therefore, to establish the bona fide relationship of the attending physician to the patient necessary to qualify for fee-for-service payments under HEW regulations.

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Administrative and teaching services of a teaching physician may be paid for as hospital services under part A whereas his patient care services are paid under part B on the basis of fee-for-service. Because of difficulties encountered in the administration of this dual reimbursement arrangement, payments at two of the hospitals exceeded the reimbursable Medicare costs by about $434,000.

Recommendation: Not Implemented Because of Congressional Action

(1) At the time of issuance of GAO's report, Congress was considering legislation that would change, with certain exceptions, the basis of reimbursement for supervisory and teaching physicians from a fee-for-service basis (part B) to a cost reimbursement basis (part A). In its report, GAO supported these proposed legislative changes and recommended that if the changes were enacted, HEW should establish and maintain procedures for determining the proper amounts to be paid for supervisory and teaching physicians' services which are reimbursed on the basis of both costs and fee-for-service at the same institution.

These proposed legislative changes later became section 227 of the 1972 Amendments to the Social Security Act. However, with enactment of P.L. 93-233 as amended by P.L. 93-368, Congress delayed the effective date of the required changes of section 227 to July 1, 1976. Therefore, the changes in methods of reimbursement for supervisory and teaching physicians have not yet been implemented.

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As of December 1, 1975, SSA and its carriers had collected overpayments of about $757,000 from the six hospitals reviewed. In addition, there were outstanding overpayments to two of these hospitals amounting to about $709,000 of which about $424,000 had been referred to the Department of Justice for collection.

Title: F. More Needs to be Done to Assure That Physicians' Services--Paid for by Medicare and Medicaid--Are Necessary, B-164031(4), August 2, 1972

Findings: GAO reviewed the safeguards used by seven paying agents in five States and found that each of the seven paying agents had established systems for reviewing the necessity for physicians' services. Under these systems the agents have identified some unnecessary services for which payments were disallowed.

The paying agents independently developed their systems for detecting possible unnecessary services. As a result, the systems are based on widely varying methods. For example, one agent questions the need for more than four office visits a month; another does not question the need for visits unless they exceed 10 a month.

Although the paying agents identified many physicians with unusual patterns of services, relatively few had been investigated to determine whether services provided were necessary. For example, one paying agent in calendar year 1970 identified 539 physicians whose services had exceeded established norms but investigated only 12.

Three Medicare carriers, at GAO's request, reviewed a sample of services provided by 42 physicians to 230 patients. The

review resulted in a determination that the patterns of services for 17 of the 42 physicians indicated that unnecessary services had been provided and that investigations should have been made.

Medicare and Medicaid paying agents have not systematically exchanged information regarding physicians who had been identified as having questionable patterns of service.

Recommendations: Fully or Substantially Implemented

(1) Evaluate, through the coordinated efforts of SSA and SRS, the overall effectiveness of the paying agents utilization review systems to identify the more effective features or procedures of each system and provide information to the paying agents as to which systems and/or procedures are most effective and should be adopted.

SSA has gathered and analyzed information about the utilization review systems of all Medicare carriers and revised instructions to the carriers--Part B Intermediary Letter 70-5--to specifically outline additional parameters for prepayment and postpayment utilization controls. SRS gave priority attention to further studies and improvements of utilization review systems. These efforts include examining utilization review systems and their limitations as well as any State constraints that hamper implementation of an effective utilization review system.

Partially Implemented

(2) Establish procedures for the effective exchange of information on known or potential problems among various paying agents under Medicare and Medicaid and monitor this exchange so that paying agents will follow through on potential problem cases.

HEW published proposed regulations on April 4, 1975, to require States to report all cases referred to law enforcement officials by provider name and number so that the names of the providers suspected of abusing Medicare or Medicaid will be made available to SSA and SRS.

(3) Provide guidance to paying agents for identifying the patterns of medical services which warrant further investigation, encourage the investigation of these patterns to the fullest extent possible, and require that evaluations of the need for medical services be based on professional medical judgement.

SSA has revised Intermediary Letter 70-5 to provide additional guidance to Medicare carriers for identifying situations which warrant further investigation. It also requires review where appropriate and the use of professional medical judgement in evaluating the need for medical services.

SRS has provided assistance to some of the States to help them improve their Medicaid utilization review systems. The model Medicaid Management Information System developed by HEW includes subsystems which provide the data States need to conduct utilization reviews. However, many of the States have not implemented the model system or an equivalent system. Also many States still have less than adequate utilization review systems.

Title: G. Problems Associated With Reimbursements to Hospitals for Services Furnished Under Medicare, B-164031(4), August 3, 1972

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Findings: GAO's review at 14 hospitals in 5 States identified several problems in the administration of the Medicare hospital reimbursement system and questioned net charges to Medicare of about $622,300 involving payments to 12 of the 14 hospitals. Causes of the questionable payments were as follows:

--Hospitals may provide services to Medicare patients which are not covered by the program, such as private-duty nurses, television, or telephone service. Costs of research and educational or commercial activities not directly related to the care of patients are not chargeable to the Medicare program. Ten hospitals overcharged Medicare about $238,500 principally because of difficulties in identifying the costs of services not covered under Medicare. The intermediaries had not reviewed this area sufficiently during their audits.

--Under HEW regulations, certain revenues received by hospitals must be deducted from the related costs to determine the share of the costs to be paid by Medicare. For example, interest earned was not deducted from interest expense and gifts or grants for specific purposes were not deducted from the related costs. Six hospitals experienced problems in identifying all the revenues that should have been deducted. As a result, Medicare was overcharged by about $30,800.

--Medicare pays a larger share of hospital costs for inpatient services than for outpatient care. Incorrect allocations of hospital costs resulted in net overcharges to Medicare of about $136,000 at 12 hospitals.

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--Statistical and payment data used by seven hospitals in computing Medicare's share of hospital costs and/or in computing cost settlements was incomplete or inaccurate because computer programs contained errors and/or because hospitals and intermediaries did not base their audits and settlements on the most up-to-date data available. As a result, Medicare made net overpayments of $64,200, consisting of overcharges of $150,000 and undercharges of $85,800.

--Four hospitals did not claim all the costs permitted by HEW regulations. Also computation errors were made on their cost reports. These actions resulted in understatements of certain allowable costs amounting to about $22,800.

--Five hospitals charged Medicare about $175,300 more than the hospitals paid for services rendered by hospital based radiologists and pathologists.

GAO also noted that about $19,000, or 30 percent, of the bad debts charged to Medicare by 19 hospitals (including six of the 14 reviewed in detail) in three States should have been paid by the States under their Medicaid or Old Age Assistance programs and not by Medicare.

Recommendations: Fully or Substantially Implemented

(1) HEW, through SSA, should inform all intermediaries about the problem areas of hospital reimbursements discussed in the GAO report.

SSA distributed copies of the GAO report to all Medicare intermediaries.

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(2) HEW, through SSA, should also emphasize to the intermediaries the need for certain actions to improve their audits to insure that Medicare payments are made in accordance with the law and with regulations.

Since the issuance of this GAO report, SSA has made efforts toward finding solutions to problems that arise, and also toward ways of improving the effectiveness of intermediary operations with particular emphasis on the auditing of hospital costs. SSA has refined and sharpened its directives and instructions to hospitals and intermediaries and improved its monitoring of their activities.

The actions taken by SSA have enhanced hospitals', intermediaries' and others' understanding of the Medicare program and the underlying cost reimbursement principles and policies. These actions have corrected many of the problems in the administration of the Medicare hospital reimbursement system and should save substantial Medicare funds.

Title: H. Sizable Amounts Due the Government By Institutions That Terminated Their Participation In the Medicare Program, B-164031(4), August 4, 1972

Findings: When many health-care institutions terminated participation in Medicare, they owed the program millions of dollars. The five intermediaries reviewed in three States made overpayments of about $8.1 million

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to 384 of the 700 institutions in these States which had terminated Medicare participation from the program's inception through April 1970. As of November 1970, 76 of the hospitals and 194 of the extended-care facilities still owed the program about $4.6 million. Overpayments resulted from:

--Payments based on estimated costs that were higher than actual costs.

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

--Tentative settlement payments--those based on the institutions' unaudited cost reports--proved to be excessive when intermediaries audited the cost reports.

Recommendation: Fully or Substantially Implemented

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

The Bureau of Health Insurance established the Provider Overpayment Reporting System which produces overpayment data on a

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national basis and provides a monitoring vehicle which affords a means to control and oversee the timely collection of overpayments. This system requires specific identification of all overpayments to terminated institutions.

Under this system, intermediaries are required to report all outstanding overpayments at the end of each calendar quarter. When a provider refuses to file cost reports, HEW policies provide that all outstanding interim payments to the provider are deemed overpayments. These overpayments are required to be reported under the reporting system.

This action should supply HEW with the means to monitor the recovery of overpayments made to institutions which terminate participation in Medicare.

Title: I. Improvement Needed in the Administration of the Program to Provide Medicare Benefits for Welfare Recipients, B-164031(3), August 14, 1973

Findings: As of December 1971 about 2 million persons were enrolled through the Medicaid buy-in program for the supplementary medical benefits of Medicare. In 1971, States paid premiums of about $134 million on behalf of these persons.

Since 1966, the program has experienced major administratrive problems. As a result:

--Not all eligible welfare recipients were enrolled, because local welfare offices had not

obtained necessary information to enroll them or because identification data was not correct or complete.

--Two States received about $2.9 million in Federal funds for premiums that should have been paid entirely by the States, because the States' procedures did not adequately identify premiums paid for persons not receiving cash assistance.

--Substantial amounts of premiums were lost to the Federal Supplementary Medical Insurance Trust Fund, because SSA made refunds to States for premiums paid for persons several months after they became ineligible for the buy-in-program. Thus, while medical bills were paid from the trust fund, neither the States nor the beneficiaries were paying the related premiums. SSA, on August 31, 1972, issued regulations designed to help alleviate this problem.

Closer coordination between State and Federal agencies will be necessary to implement procedures and controls to insure that recipients are identified and enrolled within a reasonable time and to insure the Federal funds are accurately claimed.

Recommendations: Fully or Substantially Implemented

(1) SSA should require that States reconcile their lists of eligible persons with their lists of enrollees and institute appropriate procedures to periodically insure that all eligible persons are enrolled.

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SSA provided the States, on November 25, 1973, with a list of the eligible people who should be participating in the buy-in-program. By the end of March 1974, SSA had completed reconciling its list with the States' buy-in lists and identifying persons not listed who meet or appear to meet buy-in eligibility requirements.

SSA will also use its supplementary security income conversion rolls for periodically reconciling each State's buy-in list and will identify persons not listed who meet or appear to meet buy-in eligibility requirements.

(2) SRS should establish procedures to assist States in identifying and claiming funds for premiums paid for persons receiving cash assistance and determining whether States have claimed Federal funds for premiums paid for persons not receiving cash assistance and make adjustments when appropriate.

SRS issued a memorandum in September 1973 to all HEW Regional Offices telling them to include provisions in their FY 1974 work plans for assuring Federal financial participation is not claimed for Medicare buy-in premiums on behalf of people who are not receiving cash assistance.

As of November 1973, the HEW Audit Agency had conducted reviews in 5 of the 29 jurisdictions which buy-in for the medically needy and thus could be erroneously claiming Federal funds. In addition, SRS regional staff had completed desk or on-site financial reviews in 11 jurisdictions and were scheduling the remaining 18 for review.

Title: J. Need to More Consistently Reimburse Health Facilities Under Medicare and Medicaid, B-164031(4), August 16, 1974

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Findings: Intermediaries, using the same published SSA guidelines, made different interpretations about whether and how much of certain costs were allowable or reimbursable by Medicare. In some cases, the inconsistent treatment resulted in overpayments for several years. Of the 30 hospitals and skilled nursing facilities reviewed, GAO identified Medicare and Medicaid overpayments of $1,000 or more totaling about $648,000 at 18 institutions.

Although these overpayments had occurred for a variety of reasons, GAO noted instances where overpayments might have been avoided or discovered earlier by an intermediary had SSA's advice to one intermediary on a specific reimbursement question been made available to others.

There was also no apparent systematic exchange of audit information between the two programs where a common audit agreement did not exist or where audits were not made by the same organization functioning as an intermediary and as a fiscal agent.

Recommendations: Fully or Substantially Implemented

(1) GAO recommended that the Secretary of HEW direct SSA to establish more definitive guidelines and criteria for intermediaries to follow in making judgmental decisions involving reasonable owners' compensation and excessive cash.

SSA has revised its manual instructions to more clearly define what constitutes "full-time" services of owner-administrators and has established guidelines for identifying

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providers' excess uninvested cash.

These actions, if properly implemented, should provide more consistent and fairer administration in determining reasonable owners' compensation and result in savings to the Medicare and Medicaid programs if excess cash on hand is identified and invested.

Partially Implemented

(2) Require a full exchange of Medicare and Medicaid audit information when no common audit agreement has been reached between a Medicare intermediary and a Medicaid State agency or its fiscal agent.

In responding to our recommendation for the full exchange of Medicare and Medicaid audit information, HEW stated that; "Progress in persuading States to adopt the common audit has been due in large part to the fact that participation in common audits would be less costly to them than separate Medicaid audits or the charge that Medicare could impose for access to its hospital audit information. If we were to tell those States that have not yet agreed to the common audit that we will furnish Medicare audit information and results to them free-of-charge, it would be very unlikely that they would agree to join in the common audit and to share in the costs of those audits. Moreover, those States which already use the common audit would probably want to reconsider and perhaps abandon it. In short then, under present circumstances, we believe the common audit program and its continued use and growth is contingent upon our decision to

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charge State Medicaid agencies, that do not join in common audits, for any Medicare audit information they request."

Since originally commenting on the above recommendation, HEW has stated that a review of its position will be made in light of the potential impact that the disclosure of cost reports under the Freedom of Information Act would have on the Common Audit Program.

If the recommendation were implemented, the identification and recovery of overpayments to providers under both Medicare and Medicaid would be enhanced.

Not Implemented

(3) SSA should catalog and make available on request to intermediaries, Medicaid State agencies, providers, and the Provider Reimbursement Review Board all SSA decisions or specific interpretations affecting determination of Medicare's share of hospital or skilled nursing facility costs.

HEW has taken no action to implement this recommendation because HEW disagreed with GAO as to its usefulness. GAO still believes that implementation of the recommendation:

--would help prevent varying interpretations of the Medicare law, regulations, and instructions;

--would better insure that institutions are treated equally under similar circumstances, and;

--could result in savings to the Medicare program.

STATUS AS OF DECEMBER 1, 1975, OF IMPLEMENTATION OF SELECTED GAO RECOMMENDATIONS TO CONTROL UNNECESSARY MEDICAID COSTS

Summary Table

Purpose of recommendation	Recommendation number (note a)		
	Fully or substantially implemented	Partially implemented	Not implemented
Modify method of reimbursing providers	M-1	K-1, M-2, S-3	None
Increase share of cost borne by beneficiary	None	None	None
Reduce unneeded utilization	U-1	K-2, L-2, M-3, N-1, P-1, P-2, U-8	Q-1, U-9
Change benefits or eligibility criteria	None	None	None
Emphasize use of more cost effective providers	R-1, R-2, R-3, S-1, S-2	R-4, R-5, R-6, R-7, R-8, S-4, S-5, S-6, S-9, T-5	None
Improve management to control overpayments, abuses, and fraud	U-2	L-3, U-3, U-4	L-4
Reduce administrative costs	None	O-3	None
Strengthen Federal administration	T-1	K-3, N-2, S-7, S-8, T-8, U-5, U-6, V-1	None
Other	L-1, T-2	O-1, O-2, O-4, O-5, O-6, T-3, T-4, T-6, T-7, U-7, V-2, V-3	N-3

a/The letter indicates the report and the number indicates the recommendation.

Title: K. GAO has issued a series of reports on problems in the Medicaid nursing home program. These reports contain similar findings and recommendations so they will be discussed here as a group. The reports are:

Questionable Claims Under the Medicaid Program for the Care of Persons in State Institutions for the Mentally Retarded in California, B-164031(3), May 1, 1970

Problems in Approving and Paying for Nursing Home Care Under the Medicaid Program in California, B-164031(3), July 23, 1970

Continuing Problems in Providing Nursing Home Care and Prescribed Drugs Under the Medicaid Program in California, B-164031(3), August 26, 1970

Examination Into Certain Claimed Practices Relating to Nursing Home Operations in the Baltimore, Maryland Area, B-164031(3), December 4, 1970

Problems in Providing Proper Care to Medicaid and Medicare Patients in Skilled Nursing Homes, B-164031(3), May 28, 1971

Problems in Providing Guidance to States in Establishing Rates of Payment for Nursing Home Care Under the Medicaid Program, B-164031(3), April 19, 1972

Findings: California's claims for Federal funds for care provided to patients in State institutions for the mentally retarded under Medicaid were questionable. The claims were not made on the basis of the persons' need for skilled nursing care but simply on the basis of their presence in institutions certified by the State as skilled nursing homes. A HEW medical review team found that 88 percent of the patients in State institutions were not in need of skilled nursing or hospital care. At least 7 more States were claiming over $71 million of Federal funds annually for skilled nursing care for patients in State institutions for the mentally retarded. (May 1, 1970, report.)

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There were weaknesses in the procedures and practices for approving and paying for nursing home care under California's Medicaid program. Studies of 3 counties in California found that 35, 22, and 20 percent of the patients in nursing homes did not require skilled nursing care. In some cases, nursing home care was approved and paid for after the patient had died or been discharged. Also, in some cases, nursing homes were receiving full payment for the same days from both Medicaid and Medicare for the same patient. (July 23, 1970, report.)

Payments were not stopped for Medicaid patients in nursing homes where substandard conditions persist. Narcotics and other drugs were not properly controlled in nursing homes. Patients were transferred from one nursing home to another for the benefit of the attending physician or nursing home operator. These improper practices continued because the State did not have adequate procedures to ensure compliance with regulations. The problems in the nursing home program were at least in part attributable to the inadequacy of HEW administrative reviews. (August 26, 1970, report.)

Physicians were apparently being paid for signing death certificates which is against Medicaid and Medicare policy. Medicaid had in some cases paid for nursing home care after the patients had died. Also, both Medicaid and Medicare had paid for the same care in some cases. (December 4, 1970, report.)

Many of the skilled nursing homes GAO visited may not have provided proper care and treatment for their Medicaid and Medicare patients because the nursing homes were not adhering to Federal requirements for participation in the program. Many patients in the nursing homes GAO visited may not have needed skilled care and should have been provided with less intensive--and less costly--care and GAO believes, the primary cause of this problem is that HEW has not developed a yardstick or criteria

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for measuring the need for skilled care under the Medicaid program. In the absence of such criteria, each State follows its own procedures for determining the need for skilled nursing home care. Of the 378 patients evaluated in Michigan, 79 percent did not need skilled nursing care under the States' own criteria. New York and Oklahoma had not established criteria but in a limited test, using the Michigan criteria, 71 and 85 percent of the patients, respectively, did not need skilled nursing care. (May 28, 1971, report.)

HEW had not: (1) formulated and issued appropriate criteria and requirements to guide States in establishing payment rates for nursing homes; (2) enforced the Social Security Act requirement that State Medicaid plans include a description of the methods and procedures used to establish rates; or (3) instituted effective policies and procedures for reviewing and evaluating methods and procedures actually used by States to establish payment rates. In the absence of HEW criteria, the States had adopted methods for establishing rates of payment for nursing home care, which had resulted in differing payment policies and rates. These differences could have an adverse effect not only on the cost of the Medicaid program, but also on the level and quality of care given to Medicaid patients. The administration of the Medicaid nursing home program can be significantly improved through HEW's issuance of definitive criteria to guide States in establishing payment rates. (April 19, 1972, report.)

Recommendations: Partially Implemented

GAO made 18 recommendations in these 6 reports. The 3 main issues addressed by the recommendations were the need for HEW to provide guidance to the States on

(1) how to establish nursing home payment rates;

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(2) how to determine that patients do in fact require skilled nursing care; and

(3) the need for HEW to better monitor State Medicaid nursing home programs.

In enacting the Social Security Amendments of 1972, the Congress took legislative action designed to correct many of the problems in the Medicare and Medicaid nursing home programs identified by GAO and others. For example, section 249 requires skilled nursing home payments to be based on a reasonable cost-related method and section 207 requires specific utilization review methods for skilled nursing homes. HEW has taken a number of actions to implement these provisions. For example, regulations setting common standards for skilled nursing homes under both Medicaid and Medicare were published on January 17, 1974.

Also, revised regulations were published on November 29, 1974, regarding utilization review which should help ensure that patients in nursing homes do need that level of care. In addition, HEW is presently developing regulations on how States should set nursing home payment rates on a reasonable cost-related basis which the 1972 amendments require after June 30, 1976.

It should be pointed out that problems still exist in the nursing home program as evidenced by a report issued by the Subcommittee on Long-Term Care, Senate Special Committee on Aging (Senate Report No. 93-1420) and 6 supporting papers to it. Also, recent hearings pointing out problems in the nursing home program were held on July 12, 1975, by the Subcommittee on Health and Long-Term Care of the House Select Committee on Aging.

Title: L. Improvement Needed in the Administration of the Iowa and Kansas Medicaid Programs by the Fiscal Agents, B-164031(3), October 20, 1970

Findings: Neither State had established adequate controls for ensuring that Medicaid payments were made only for medically necessary services nor had either State adequately supervised or reviewed the administration of their program by fiscal agents. As a result, there were indications of overuse of program services and the States had not ascertained what the reasonable charges were for many of the types of services provided even though this was supposed to be the method of payment. A number of problems with the States' claims processing and payment system were identified.

The States needed to improve monitoring of their fiscal agents and HEW needed to improve its monitoring of the State programs. Also, HEW needed to issue guidelines and other information to all the States to assist them in improving program management and correct the weaknesses identified by GAO.

Recommendations: Fully or Substantially Implemented

(1) Provide the States with guidelines defining the States' responsibilities relative to fiscal agents' activities and the need for States to provide supervision and review of those activities.

HEW regulations defining a fiscal agent arrangement and outlining the basic requirements of such arrangements were published on February 27, 1971. More detailed regulations were published on May 9, 1975.

If the HEW regulations are fully implemented by those States using fiscal agent arrangements, the States will have more effective arrangements and should better monitor them. This should insure more effective management of the Medicaid program.

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Partially Implemented

(2) Provide the States with methods for reviewing and controlling the use of Medicaid services. Model systems should be developed for reviewing the services of major provider groups, including the manner in which reviews by professional medical groups can be used to assist States in controlling the use of Medicaid. The States should be required to adopt either the model system or locally developed systems that have been approved by HEW.

Utilization review regulations for institutional services were published on November 29, 1974, in response to a requirement in the Social Security Amendments of 1972, but portions of the regulations were subsequently withdrawn during a court action. In 1971 HEW developed a model Medicaid Management Information System which was designed to help States improve their management information and claims processing systems so they could achieve greater effectiveness in administering their Medicaid programs. HEW has not required the States to adopt the model system or locally developed systems that are at least as good.

More effective claims processing and information retrieval systems would help control Medicaid costs by helping to insure that only valid claims are paid at reasonable rates and would also provide the States with the information needed to perform effective utilization review programs. While the actions taken by HEW do provide the States with additional information on how to control costs through the use of computers and utilization review, not all States have used this information.

(3) Clarify guidelines on the need for auditing of Medicaid-related data in determining the reasonable cost of hospital care provided to Medicaid recipients. The guidelines should identify specific information to be considered in the audits and should

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contain instructions regarding the extent to which audits are required to satisfy the criteria of reasonableness.

HEW provided the States with guidelines in December 1971 on how to obtain a common audit agreement with the organization doing hospital reasonable cost audits for Medicare. However, HEW has not provided guidelines on how to conduct these audits to States which choose not to use common audits. (For a later report covering this subject see p. 60.)

If HEW provided audit guidelines to the States, there would be more assurance that hospitals are not being overpaid. Also, it would assure that hospitals are not underpaid which can cause cash flow problems to hospitals and discourage participation by hospitals in the program.

Not implemented

(4) Provide the States with guidelines that require the States to provide the agency processing Medicaid claims for payment with the identification of recipients who have private health insurance coverage. The guidelines should also require that processing agencies have procedures to consider private health insurance benefits in determining the amounts to be paid under the Medicaid program.

HEW felt that its existing regulations provided sufficient guidance so it took no action.

Since the States were having problems in identifying liable third parties, GAO believed additional guidance was needed. Medicaid is only supposed to pay for health care that no one else is obligated to cover. By determining when liable third parties exist, Medicaid expenditures can be held down.

Title: M. Controls Over Medicaid Drug Program in Ohio Need Improvement, B-164031(3), November 23, 1970

Findings: GAO estimated that during the year ending March 31, 1969, at least 4,300, and possibly as many as 9,300, welfare cases in Ohio were ineligible for Medicaid services including drugs. Ohio and 11 other States had a policy of paying pharmacies on a cost-plus-a-percentage-of-cost basis which was in violation of HEW policy. This payment method gives the providers an incentive to sell high-cost drugs to obtain a greater profit. Ohio was not even ensuring that prices paid conformed to its cost plus 50 percent payment policy and average markups were as high as 248 percent. Nursing homes were not obtaining long-term maintenance drugs in economical quantities because Ohio limits prescriptions to a 30-day supply. Ohio's controls over drugs were not adequate for either the State or HEW to determine whether (1) drugs obtained for nursing home patients were administered and effective in treatment, (2) drugs billed by pharmacies were actually received by recipients, and (3) only needed drugs were provided. Also HEW needed to give priority in its drug efficacy study to low cost, frequently used drugs identified by the HEW Task Force on Prescription Drugs as offering potential for considerable savings.

Recommendations: Fully or Substantially Implemented

(1) Provide assistance to Ohio and other States in revising their drug payment policies to conform to HEW policy.

Guidelines which provide several options for establishing drug-pricing fees were issued by HEW in 1971. None of the States now pay pharmacies on a cost-plus-a-percentage-of-cost basis.

Implementation of this recommendation has removed the incentive pharmacies had in cost-plus States to provide high cost drugs. This should help control Medicaid drug program costs.

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Partially Implemented

(2) Give priority in the conduct of HEW's drug efficacy studies to those drugs identified by the HEW Task Force on Prescription Drugs as having considerable potential for savings and provide physicians with information on the results of the studies.

The thrust of this recommendation was that HEW should encourage physicians to prescribe lower cost generic drugs instead of higher priced brand name drugs. On August 15, 1975, HEW issued regulations limiting Federal participation in the cost of drugs prescribed for Medicaid patients to the cost of the least expensive, generally available generic drug for those types of drugs most frequently prescribed.

When the regulations are fully implemented, HEW expects to save $48 million in Medicaid drug funds each year. However, a law suit has been initiated against the implementation of the regulations.

(3) Issue guidelines for utilization reviews of drugs so that the States will have a uniform system for accumulating, analyzing, and reporting data for use by HEW and the States in evaluating Medicaid drug programs and then monitor the implementation of these guidelines and give assistance to the States as needed.

HEW has not issued guidelines for utilization review of drugs. HEW has developed a model Medicaid Management Information System which contains components that would aid the States in controlling the use of drugs. However, States are not required to implement this or a similar system. HEW has limited staff to monitor State utilization control programs and most of their time is spent on utilization control programs for institutional services and not on noninstitutional services such as prescription drugs.

Title: N. Control Needed Over Excessive Use of Physician Services Provided Under the Medicaid Program in Kentucky, B-164031(3) February 3, 1971

Findings: HEW had not provided the States with guidelines for evaluating the need, quality, quantity, or timeliness of medical services provided under Medicaid nor had it adequately supervised or monitored Kentucky's evaluation of medical services that were provided. GAO selected a sample of 100 recipients identified by the State as being large prescription drug users. Of these, 84 received an excessive number of prescriptions (an average of 18 prescriptions a month) and 62 overused physician services. An obstacle to examining and evaluating the quantity and/or frequency of physician services was HEW's regulation allowing providers up to 2 years to submit Medicaid claims.

Recommendations: Partially Implemented

(1) Provide the States with guidelines to assist them in effectively reviewing the use of physician services, including limits as to the quantity and/or frequency of medical services.

HEW has not issued such guidelines but it has developed a model Medicaid Management Information System which contains components which can aid States in controlling the use of physician services. However, States are not required to implement this or a similar system.

If detailed guidelines on how to implement a utilization review system for medical services provided under Medicaid were issued, they would assist States in developing better utilization control programs. Such programs help ensure that only medically necessary services are paid for by Medicaid.

(2) Increase monitoring of the States' evaluations of physician services.

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HEW has limited staff to monitor and evaluate State's utilization control activities. Almost all of HEW's effort is directed to utilization control in institutions and little on noninstitutional services such as those provided by a physician.

Monitoring and evaluating State utilization control programs should help to ensure that States do have effective programs.

Not Implemented

(3) Reduce the 2-year period during which providers may bill for services provided to Medicaid recipients.

HEW has taken no action on this recommendation.

If the period of time during which providers may submit claims was reduced, it would make it easier for States to monitor the use of the Medicaid program by both recipients and providers.

Title: O. Ineffective Controls Over Program Requirements Relating to Medically Needy Persons Covered by Medicaid, B-164031(3), July 28, 1971

Findings: California, Illinois, and Massachusetts had encountered difficulties in administering the medically needy portion of the Medicaid program. Medicaid had paid for medical services that should have been paid by the recipients.

Eight States had set income levels for medically needy eligibility in excess of the Federally established maximum, but HEW shared in State costs without determining if the States had only claimed sharing for eligibles with incomes below the Federal maximum.

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

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

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

The effectiveness of the quality control system in Illinois was reduced because the State had reviewed less than the minimum number of cases specified by HEW.

Recommendations: Partially Implemented

HEW should

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

(2) after identifying these procedures either (1) disseminate the information to the States with the recommendation that the procedures be followed or (2) develop a model system for use by the States;

(3) consider the practicability of controlling the administration of the recipients' share of cost in cases in which the amount is small or the required controls are burdensome;

(4) consider alternative approaches to cost sharing if it is determined that the administration of the present share-of-cost aspect of the program cannot be made practicable;

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

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

HEW commented in January 1972 on this report that "* * * the Social and Rehabilitation Service has requested all regional offices to review and report on the procedures used in those States that cover the

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medically needy to assure that the recipient's income is properly taken into account in paying medical bills and claiming Federal financial participation. We also asked the regions to review the controls used to assure that other medical payments properly made under the State plan, but not subject to Federal financial participation, are excluded from the Federal claim. However, because of severe staffing shortages at the regional level and at the Washington headquarters of SRS this work has not yet been completed. Its completion is dependent upon the availability of staff time within the several organizational units directly involved in the problem. Since we are most concerned that this work be accomplished within the reasonably near future, we have assigned it an appropriately high priority. After this evaluation phase is completed we will then carry out the remaining parts of the GAO recommendation. In the meantime, the Department is pursuing corrective action in individual State situations where review work has shown that procedures are ineffective."

However, we recently completed a review of the medically needy eligibility determination process in Illinois and New York. A report was issued to HEW on October 17, 1975. We identified several deficiencies in the report similar to those previously identified. As of December 1, 1975, we had not received HEW's comments on the report so we do not know what actions HEW has taken to correct the problems.

Title: P. Functioning of the Missouri System for Reviewing the Use of Medical Services Financed Under Medicaid, B-164031(3), March 27, 1972

Functioning of the Florida System for Reviewing the Use of Medical Services Financed Under Medicaid, B-164031(3), June 9, 1972

Functioning of the Massachusetts System for Reviewing the Use of Medical Services Financed Under Medicaid, B-164031(3), November 24, 1972

Functioning of the Maryland System for Reviewing the Use of Medical Services Financed Under Medicaid, B-164031(3), December 21, 1972

Findings: This series of reports was requested by the Chairman, House Committee on Ways and Means. In each of the reports we identified a number of weaknesses in the utilization review system of the State involved. Utilization review is one of the primary methods available to States to control Medicaid costs.

Recommendations: Partially Implemented

GAO made a number of recommendations in each of the four reports. The thrust of these recommendations was that

(1) HEW should assist States in developing effective utilization review systems; and

(2) HEW should ensure that the model Medicaid Management Information System it was developing contain features which would provide the information needed by States to have effective utilization review systems.

HEW has provided assistance to some of the States to help them improve their utilization review systems. The model information system developed by HEW includes subsystems which provide the data States need to

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conduct utilization reviews. However, many of the States have not implemented the model system or an equivalent system. Also, a number of States still have less than adequate utilization review systems.

An effective utilization review system helps assure that only medically necessary services are provided to Medicaid recipients and paid for by Medicaid funds. An effective system also helps identify providers and recipients who are abusing or defrauding the Medicaid program. States with an effective utilization review system have a greater assurance that Medicaid funds are being expended economically and effectively than do States without such a system.

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Title: Q. Medicaid Expenditures for Ineffective or Possibly Effective Prescription Drugs, B-164031(2), February 15, 1974

Findings: In December 1970, the Surgeon General requested all agencies within HEW to prohibit the use of Federal funds for ineffective and possibly effective prescription drugs and in May 1972 GAO recommended that SRS prohibit the use of Medicaid funds for them. However, based on data for September 1973, GAO estimated that California, Ohio, and Texas were expending funds at an annual rate of about $8.3 million for drugs which the Food and Drug Administration had classified as ineffective or possibly effective.

In December 1974, the Chairmen of the Senate Committee on Finance and the House Committee on Interstate and Foreign Commerce sent letters to the Secretary asking why GAO's recommendations had not been implemented. The Secretary replied that regulations implementing the recommendation would be published shortly.

Recommendations: Not Implemented

(1) Expedite publication of regulations prohibiting the use of Federal funds for the purchase of ineffective and possibly effective drugs under Medicaid and establish procedures for providing the States and drug providers lists of drugs classified as ineffective or possibly effective and lists of all identical, related, and similar drugs.

HEW has taken no action to implement this recommendation.

If the recommendation were implemented, Federal Medicaid funds would be more effectively used and the health care of eligible individuals would be improved through the substitution of drugs having evidence of effectiveness for drugs having little or no evidence of effectiveness.

Title: R. Home Health Care Benefits Under Medicare and Medicaid, B-164031(3), July 9, 1974

Findings: Home health care, while not a substitute for appropriate institutional care, is generally a less expensive alternative when such care would meet the patient's needs. The Congress and the health field have realized the need for developing alternatives to institutional care. Home health coverage under Medicare experienced significant difficulties in its early stage. Although some problems have been alleviated, obstacles continue to diminish its overall effectiveness. Intermediaries have established different guidelines for the periods and the number of home health visits covered for various illnesses. As a result there are disparities in the extent of benefits paid for by intermediares. Information provided to beneficiaries by SSA on allowable care has not always clearly spelled out limitations of the coverage. Accordingly, beneficiaries, at times, have been confused regarding the coverage and limitations of home health benefits.

Physician and hospital involvement is essential to a successful home health care program. Physician involvement, however, has been limited and hospitals have not always encouraged effective use of home health care. A major problem for home health agencies and beneficiaries had been denial of payments after services had been furnished by home health agencies. Although this problem has subsequently been reduced, some agencies still have denial problems. GAO found with regard to Medicaid:

--Services covered under the States' programs vary significantly.

--Some States have adopted Medicare eligibility criteria which are more restrictive than intended by Medicaid.

--States' payment rates for home health care have not been adequate.

Recommendations: Fully or Substantially Implemented

(1) Explore methods of further clarifying Medicare program benefits, especially the limits on the duration of benefits in an effort to reduce confusion on the part of beneficiaries.

"Your Medicare Handbook" was revised to clarify Medicare home health benefits and was distributed in mid-December 1974. All currently enrolled Medicare beneficiaries received a copy. It was also sent to concerned national organizations for further dissemination.

An increased awareness of Medicare home health benefits should enable more use of the benefit. Since home health care is generally less expensive than institutional care, increased use of it could reduce overall Medicare costs.

(2) Determine whether implementation of the Medicare advance approval and waiver of liability provisions is effective in minimizing the problem of denials and, if necessary, advise the Congress that the amendments need modification to correct the problem.

The interim instructions for the implementation of the waiver of liability provision were issued in March 1973. With the passage of time, it became evident to HEW that some of the provisions were too restrictive for many home health agencies. Contact with operating providers was initiated and the waiver provisions were reworked. The new regulations were published in the Federal Register of January 6, 1975. As a result of the overall revisions the time frames for the submission of start of care notices and other medical evidence was materially liberalized.

(3) Encourage the States to establish payment rates for home health care at a level that will stimulate greater utilization of Medicaid home health care.

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SRS is continuing to emphasize the importance of realistic payment rates as a means of encouraging more frequent use of home health care services. A recent survey has shown that more and more States are switching to the Medicare formula for determining the rate of reimbursement.

An Interagency Task Force on Home Health Services undertook a study to determine methods of reimbursement for home health services by the various State Medicaid agencies.

In 1970 there were 15 States that utilized a system of fixed fees, negotiated rates, or schedule of allowances to reimburse home health agencies. In July 1974, SRS requested the regional offices to contact the States that had been paying a fixed fee to determine whether they were continuing to use the same method, and if so, what the maximum fee is.

The majority of States have some system of reimbursing for home health services on a cost related basis. Only Missouri continues to pay an unrealistic rate and has not made any payment rate adjustment since 1970. At that time payment was $7 for a registered or licensed practical nurse visit--the only service the Medicaid agency provides under its home health services plan.

Paying reasonable rates for home health care encourages more home health agencies to participate in the program and thus make the service more available.

Partially Implemented

(4) Establish regulations, as authorized by the advance approval provision of the Social Security Amendments of 1972, to specify for Medicare limited coverage periods, according to medical condition, during which a patient would be presumed to require a covered level of post-hospital home health care services.

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Proposed regulations implementing section 228 of P.L. 92-603, which provide for presumed coverage of post-hospital extended care and post-hospital home health services were published as proposed rules in the Federal Register on July 9, 1975.

When the proposed regulations are finalized, it should help increase the use of home health benefits by reducing the uncertainty that has existed over whether payment would be retroactively denied by Medicare.

(5) Increase its effort to assure more effective and uniform interpretation of existing instructions to intermediaries and home health agencies regarding the various coverage requirements for home health services.

HEW is conducting a study to analyze the reviews that intermediaries make of home health agency claims.

More consistent application by intermediaries of home health benefit guidelines should encourage greater use of the benefit.

(6) Review screening guidelines used by intermediaries and where significant differences exist, explore the feasibility of requiring intermediaries to apply more uniform screening guidelines.

HEW asked 34 intermediaries to submit a sample of claims processed in February 1974, including both denied and approved claims. The claims are being analyzed to determine the correctness of the intermediaries' decisions on denials and approvals. In addition, all Medicare intermediaries were asked to submit screening guidelines they use to review home health claims.

HEW plans to issue a final report on the total sample of claims. The report will focus on the amounts of home health services approved by individual intermediaries for specific diagnosis. Information on denied

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claims will be included, such as reasons for denials, processing times, and denials made on a prospective basis.

When completed these actions should lead to a more uniform national Medicare home health care policy.

(7) SSA and SRS should encourage and, where considered feasible, assist home health agencies in their efforts to increase the awareness and support by the health field of home health care.

A directory of home health agencies and the individual services provided by each is being prepared for community distribution. This publication is being accomplished with the active cooperation of several State and national home health organizations. This action should help to increase the awareness of the health community of the availability of home health care.

(8) Clarify for the States the specific home health services which are eligible for Medicaid Federal financial participation and define these services.

Proposed regulations were published on August 21, 1975, clarifying which services are eligible for Federal financial participation. When finalized, these regulations should provide the States with the information necessary to establish their home health programs.

Title: S. Better Controls Needed for Health Maintenance Organizations Under Medicaid in California, B-164031(3), September 10, 1974

Findings: A basic objective of using prepaid health plans under Medicaid is to reduce the cost of providing health care services to recipients. California paid prepaid health plans on the basis of what it expected to pay per recipient under the fee-for-service health system. Because this payment method does not reflect the differences in the need for and use of health services between those recipients who enroll in prepaid plans and those who choose to remain in the fee-for-service system, cost savings may not have been realized.

There was an average monthly turnover rate of 6.2 percent during the period November 1972 through October 1973 about half of which was accounted for by voluntary disenrollments. Many of the disenrollments resulted because the recipients believed the plan was misrepresented when they enrolled.

The State's monitoring system needed improvement to insure that prepaid plans (1) promptly processed requests for disenrollment, (2) accurately reported reasons for disenrollment and (3) established appropriate grievance procedures through which recipient complaints can be channeled.

The State's evaluations of the quality of care provided by prepaid plans had not been performed in sufficient depth to insure that quality care is being provided. Also, the State could make better use of available data concerning medical services and recipient complaints in its medical audits of prepaid plans.

Recommendations: Fully or Substantially Implemented

(1) Require the States to insure that all HMOs establish grievance procedures.

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HEW published regulations on May 9, 1975, which require States to ensure that HMOs have grievance procedures.

If HMOs have adequate grievance procedures, it should help maintain recipient satisfaction with the HMO which should lead to more stable enrollments.

(2) Require the States to establish procedures to monitor HMO enrollment and disenrollment practices and insure proper implementation of HMO grievance procedures.

HEW regulations now require the States to monitor these aspects of their HMO programs.

State monitoring of enrollment and disenrollment practices and grievance procedures should help eliminate abuses in these areas. Elimination of abuses would make the HMO program more attractive to recipients.

Partially Implemented

(3) Provide guidance to California and other States with Medicaid HMO programs, in establishing HMO rates. Such regulations should include requirements that States document the basis for HMO rates negotiated and that these rates reflect differences in the need for and use of health services required by the population served by the HMOs compared to the general Medicaid population.

The May 9, 1975, regulations require that States document the basis for rates negotiated with HMOs. However, States have not as yet been provided guidance on how to set rates which reflect the difference in the need for and use of health services required by the population served by the HMOs compared to the general Medicaid population. SRS has awarded several contracts designed to develop methods States could use to set rates which reflect these

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differences. SRS has also provided actuarial assistance to a number of States.

In order to ensure that the savings anticipated by initiating Medicaid HMO programs are realized and that HMOs are not paid excessive rates, the rates must be established on a basis which reflects the need for and use of services of the enrolled population. When HEW completes action on GAO's recommendation, States should be able to establish rates in such a manner.

(4) Establish procedures for controlling HMO enrollments and disenrollments.

HEW's May 9, 1975, regulations require States to have procedures for controlling enrollments and disenrollments. However, the regulations did not provide guidelines on how to do so. Such guidelines are under development by HEW.

If States establish procedures for controlling HMO enrollments and disenrollments, abuses in these two areas should be minimized. Abuses in California caused a rapid turnover in enrollees and lessened the appeal of the program. This may have kept recipients from enrolling and thus diminished the potential for obtaining the benefits supposedly available from HMOs.

(5) Identify management data, such as reasons for disenrollment and use of services, which can be advantageously used by the States to monitor HMO quality of care and devise procedures to insure that accurate, standardized data is available to HMO audit teams.

(6) Prescribe the types of action States must take to insure that HMOs provide quality medical services.

HEW believes that the state-of-the-art in HMO quality of care assurance is not sufficiently advanced to allow regulation of what States must do in this area. HEW

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hopes that developments under the Health Maintenance Organization Act of 1973 will, in the future, enable more definitive guidelines in this area.

HEW officials also said that they intend to reexamine the May 9, 1975, regulations after they have been in effect for a year to see if additional strengthening is needed in the quality assurance area. The officials also said that HEW stresses the need for HMO quality assurance programs in its technical assistance activities with the States.

(7) Establish a Federal surveillance mechanism to insure that HMO costs do not exceed the cost of providing similar services under fee-for-service.

(8) Establish a monitoring system to insure that States comply with Social and Rehabilitation Service regulations.

HEW officials said that monitoring under the Medicaid program is done at two levels: (1) by the Regional SRS Financial Management staff and (2) by the HEW Audit Agency. The results of the actuarial studies contracted for by HEW will be used to develop protocols for monitoring HMO costs by these two staffs. HEW officials believed that their standard procedures were sufficient to monitor the other HMO regulations.

If HEW properly monitors State Medicaid HMO programs, there will be more assurance that the States are meeting Federal requirements. Monitoring of the implementation of the regulations issued in response to GAO's recommendations should ensure that States are preventing the abuses GAO identified. Monitoring of State HMO rate setting procedures, when HEW establishes the procedures for doing so, should ensure that the savings anticipated from Medicaid HMO programs are in fact realized.

(9) Develop a model system for State monitoring of HMOs, drawing on California's experience to help other States avoid the problems California has had.

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HEW is studying a proposal submitted by California for developing a model system for State monitoring of HMOs. A grant award for development is expected.

If HEW provides a model system to the States, they will be better able to assure that the cost savings potentially available from using HMOs are realized and that HMOs do provide quality health care to enrolled Medicaid recipients.

Title: T. Improvements Needed to Speed Implementation of Medicaid's Early and Periodic Screening, Diagnosis, and Treatment Program, MWD-75-13, January 9, 1975

Findings: States were required by law to fully implement the early and periodic screening, diagnosis, and treatment (EPSDT) program by July 1, 1969. The idea behind the program is that prevention and early detection of disease will in the long run save funds for the Medicaid program. However, HEW did not issue implementing regulations until February 1972 which slowed State implementation of the program.

As of June 30, 1973, none of the 8 States reviewed had fully implemented an EPSDT program. States needed to increase outreach efforts to insure that eligible children use the program. States also needed to make more use of allied health professionals, especially in physician shortage areas, so that more children could participate in the program. States were not meeting their target screening schedules and were not insuring that conditions identified by screenings were treated. HEW had not been aggressively pursuing implementation of the program.

Recommendations: Fully or Substantially Implemented

(1) Take more aggressive action, including formal compliance hearings, to make States comply with the law and SRS regulations.

HEW can exercise either of 2 options if States fail to comply with EPSDT laws and regulations. One is to initiate formal compliance hearings. The other is to assess penalties against the States. HEW feels that compliance hearings are not as effective as levying penalties. Thus far, no compliance hearings have been initiated; however, nine States have been assessed penalties for not fully implementing EPSDT during the first quarter of FY 1975.

As of December 1, 1975, the following States had been penalized:

	Amount of penalty
California	$1,926,439
Hawaii	72,904
Indiana	143,516
Minnesota	280,997
Montana	27,889
New Mexico	70,646
New York	2,300,000
North Dakota	26,206
Pennsylvania	1,048,411

These States are now in the process of appealing the EPSDT penalties.

Aggressive action such as withholding Federal funds from States that are not fully implementing Medicaid laws or regulations should prompt more States to comply with the law and HEW regulations.

(2) Require States to establish procedures to follow up on children with problems identified during the EPSDT screening process to insure that needed treatment is provided.

HEW has required the States to improve their management information systems to provide follow-up procedures to insure that needed treatment is provided and, if treatment is not provided, it is not as a result of State action or inaction.

If the States properly implement this new requirement, it should result in children receiving the treatment indicated by screening. This in turn should help prevent the children's health from deteriorating.

Recommendations: Partially Implemented

(3) Encourage the States to use outreach techniques in the EPSDT program, such as personal contacts, in addition to the required annual written notification.

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Proposed regulations published on August 20, 1975, specify more clearly the required content of the outreach techniques, in order to assure that recipients can make an informed judgment on acceptance or refusal of the services, and to assure a valid offer of EPSDT services by the State to the recipients. According to the proposed regulations, if a recipient accepts the offer of services but fails to show for the services, at least one more contact (preferably actual visit) should be made with the recipient. HEW has advised the States that Federal financial participation at the 75% administrative rate is available to contract with volunteer and other community organizations for outreach activities for EPSDT.

When the proposed regulations are finalized and implemented by the States, more children should be screened because, as shown in GAO's review, outreach efforts have been effective in getting eligible persons to participate in the program.

(4) Develop criteria for determining which children do not need EPSDT screening because they are receiving regular, adequate medical care equivalent to screening and disseminate the criteria to all States so that screening efforts are directed toward children who need it.

HEW has sent to the States for comment guidelines defining criteria for determining equivalents to screening.

When the guidelines are finalized and implemented by the States, screening efforts will be directed toward those most in need of them and available health manpower should be better utilized.

(5) Encourage and help States to use allied health professionals for screening eligible children, especially in those areas that have a shortage of physicians.

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A manual for training allied health professionals to conduct screenings is being prepared. States will also be offered Federal funds at the 75% administrative rate to hire additional personnel for this purpose.

When the manual is published, and if the States use it, additional personnel will be available to conduct screenings and, therefore, more children should be able to be screened. This is especially true in areas with physician shortages.

(6) Encourage and help States to increase their screening efforts to insure that all eligible children are screened.

HEW has authorized 55 more people in its regional offices and 26 in Washington, D.C. to implement the EPSDT program. Those assigned to Washington will form the Technical Assistance Unit which will work directly with the States on EPSDT. HEW has also devised a Program Improvement Plan where HEW and State officials meet to analyze the weaknesses in the States' EPSDT programs and help the States develop more complete programs. HEW has also entered into several contracts to help strengthen the weaknesses in States' programs. One contract is with the Community Health Foundation of Glenview, Illinois. This organization will conduct a need assessment for health services in nine States which have requested SRS assistance. Another contract was entered into with the American Medical Association which will conduct studies on alternatives to physician staffs at EPSDT sites. Contracts have been signed with the American Academy of Pediatrics and the National Council of Organizations of Children and Youth to provide technical assistance on improved outreach techniques, informing and tracking mechanisms. Each contract is for a one year period which began on June 30, 1975.

When completed, the increased assistance to the States should result in more eligible children being screened.

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(7) Encourage and help States to establish procedures to insure that EPSDT screenings are periodically updated.

A model EPSDT information system is being developed for Georgia. The knowledge gained from this model will be useful in other State programs, according to HEW, in establishing procedures to insure that screenings are periodically updated.

When the information system is developed and implemented, it should help insure that screenings are periodically updated.

(8) Monitor States' progress in meeting their EPSDT screening schedule.

SRS has authorized 55 additional positions in the regions for EPSDT staff. HEW believes these additional personnel will increase its capability to monitor State EPSDT programs.

When the newly authorized regional EPSDT positions are filled, it should enable HEW to more closely monitor State progress in meeting their screening schedules. Increased monitoring should help insure that States meet their schedules.

Title: U. Improvements Needed in Medicaid Program Management Including Investigations of Suspected Fraud and Abuse, MWD-75-74, April 14, 1975

Findings: Between October 1, 1969, and September 30, 1974, HEW Regional offices reported about 2,300 instances in which States did not comply with Federal Medicaid requirements. However, HEW has not imposed monetary penalties against any State for noncompliance with the requirements.

SRS did not have, in its headquarters or regions, a unit (1) to assist States in identifying Medicaid fraud and abuse, (2) insure that States comply with Medicaid Federal fraud and abuse regulations, (3) coordinate with Medicare on fraud and abuse matters, or (4) investigate suspected cases of Medicaid fraud and abuse. Many States also had weak fraud and abuse detection mechanisms. In fact, 20 States have never referred a suspected fraud case to State or Federal law enforcement agencies for prosecution. Improved coordination of State Medicaid fraud and abuse investigations with Federal Medicare investigations was needed and a combined Federal Medicare-Medicaid investigate unit should improve HEW's ability in this area.

SRS had not (1) given sufficient attention to reviewing States' Medicaid operations, (2) obtained or analyzed needed data to provide indicators of the effectiveness of State programs, or (3) given adequate consideration to recommendations by consultants and the HEW Audit Agency for correcting program deficiencies. Many of the deficiencies identified by GAO had also been identified in a February 1970 report prepared by the staff of the Senate Committee on Finance.

Many deficiencies were identified in the system used by Illinois for paying Medicaid claims. Also, Illinois' utilization review program was very weak. HEW had also identified weaknesses in many State utilization

review programs, but had not penalized the States as required by the Federal Medicaid Law.

Recommendations: Fully or Substantially Implemented

(1) Insure, before approving Medicaid Management Information Systems, that State proposals for such systems provide data needed to perform effective utilization reviews and provide for an efficient system for paying claims under Medicaid.

HEW's existing requirements, contained in 45 CFR 250.90 (May 20, 1974), and in the criteria for determining Federal financial participation in State payments for mechanized systems (MSA-PRG-31, June 10, 1974) requires that State proposals for Medicaid Management Information System matching funds include the data and reports necessary to manage an effective utilization review program. The States must comply with these requirements to receive higher matching for operation of the MMIS system. The system will provide feedback and support materials for institutions performing the utilization review function.

Utilization data obtained by States which follow these guidelines should be useful in identifying and preventing inappropriate utilization of medical services.

(2) Establish a single unit for the systematic, coordinated investigation of suspected fraud and abuse under both Medicaid and Medicare.

HEW established in December 1975 an office responsible for these activities. GAO believes that a single investigative unit at the Federal level should be more economical and efficient. It should also help insure that Medicaid and Medicare investigations are coordinated.

Partially Implemented

(3) Insure that all States comply with Federal requirements for investigating suspected Medicaid fraud and abuse cases.

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SRS established a Fraud and Abuse Surveillance Branch in its headquarters and plans to establish such units in its regional offices. These units will be assigned responsibility for monitoring and assisting State fraud and abuse detection efforts. These units are in addition to the HEW wide investigation office. HEW is also developing provider review guides which will be used to determine and measure the rate and characteristics of Medicaid fraud and abuse.

When these actions are fully implemented, it should enhance HEW and State capabilities to detect fraud and abuse. Better detection should provide a deterrent to fraud and abuse in Medicaid.

(4) Insure that States coordinate their investigations of suspected Medicaid fraud and abuse more closely with Medicare investigations.

HEW published proposed regulations on April 4, 1975, to require States to report all cases referred to law enforcement officials by provider name and number. This would facilitate coordination of Medicaid and Medicare investigations. HEW also plans to issue instructions to its regional offices detailing the referral responsibilities between Medicaid and Medicare staffs.

When these actions are completed it should improve HEW's coordination of Medicaid and Medicare investigations. Improved coordination should insure that providers detected defrauding or abusing one of the programs will be investigated by the other program.

(5) More effectively monitor States' Medicaid operations.

HEW regional Medicaid staffs have been authorized more personnel. SRS plans to review Medicaid operations in several States and, with State personnel, develop corrective action plans if necessary. SRS also

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plans to follow-up to insure that the corrections are made.

Increased monitoring of State Medicaid operations should enable SRS to evaluate the accomplishments of, and identify management weaknesses in, State Medicaid programs. This in turn should help to improve the management of the Medicaid programs.

(6) Revise State Medicaid reporting requirements to include data that will provide indicators of the effectiveness of States' operations.

HEW has awarded a contract for a study to determine what information would provide indicators of program effectiveness that are not presently reported. HEW also plans to assess State information systems to determine what information exists that would be useful to State Administrators or HEW in evaluating program effectiveness.

The results of these efforts, when completed, should provide HEW with a better data base for determining program effectiveness. It should also better enable comparisons among States and help identify potential problem areas.

(7) Insure that HEW regional offices and States give adequate consideration to recommendations made by consultants and the HEW Audit Agency to improve States' Medicaid operations.

HEW plans to direct its regional officials to review the recommendations made by the HEW Audit Agency and consultants and determine what action has been taken by the States to correct deficiencies. If the States have not corrected the deficiencies, the regional officials will be directed to take appropriate action.

When implementation of GAO's recommendation is completed, it should help insure that the results of HEW Audit Agency audits and

consultant contracts are more fully utilized. This should improve the management of the Medicaid program.

(8) Increase technical assistance to the States to develop effective utilization review systems.

HEW has, and is, providing technical assistance to the States to help them develop more effective utilization review systems for institutional services.

HEW's increased technical assistance should help States develop their utilization review systems which help control costs by checking to make sure that only medically necessary services are provided. However, almost all of HEW's assistance has been directed toward institutional services and, as GAO's report pointed out, utilization review of noninstitutional services also needs to be improved.

Not Implemented

(9) Assess penalties on States that fail to comply with utilization review requirements.

The Secretary of HEW has informed the Chairman, Subcommittee on Investigations and Oversight, House Committee on Interstate and Foreign Commerce, that, while he realized that he is required by law to impose these penalties, he is not planning at this time to impose them. He has instructed his staff "to make an in-depth review of the penalty provision to see if more appropriate incentives could be designed that will result in the improvement of State utilization control programs." The Secretary has taken this position because he believes the magnitude of the required reductions would be harmful to the overall Medicaid program.

The Congress intended this penalty provision to serve as an incentive for States to develop effective utilization review programs for institutional services.

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Such systems have been required for many years, but are still lacking in a number of States.

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Title: V. Need for Closer Monitoring by the Social and Rehabilitation Service of State Reimbursements of Hospitals for Inpatient Services Furnished Under Medicaid, MWD-75-78, May 9, 1975

Findings: States were not complying with HEW regulations on reimbursements for inpatient hospital services and SRS has not taken effective action to insure that States comply. At the end of 1972, 15 of the 28 States we were able to obtain information from had outstanding overpayments of $20.4 million and 8 States had underpayments of $16.6 million. Also, 4 of the 29 States from which we obtained data on settlement procedures had never made final cost settlements, 8 States had not made tentative settlements, 2 States did not require hospitals to submit cost reports, and 14 States had either incomplete or no statistics on over or underpayments.

Recommendations: Partially Implemented

HEW should

(1) more closely monitor State activities regarding reimbursement for inpatient hospital services by insuring that tentative and final settlements are made with hospitals as required by Federal regulations and, where appropriate, retroactive adjustments are made;

(2) take action to recover amounts due the Federal Government because of States' failure to reduce Medicaid claims to consider the nursing salary cost differential; and

(3) insure that outstanding overpayments and underpayments discussed in this report are collected or paid.

In response to GAO's recommendations, SRS Regional Commissioners have been instructed by the Acting Administrator of SRS to assign a priority to reviewing State reimbursements for inpatient hospital services

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paid for by Medicaid and to inform the Acting Administrator when any overpayments or underpayments are collected or paid.

When these recommendations are fully implemented by HEW it should help insure that hospitals are not over or underpaid by the States and that States do not improperly claim Federal sharing. Implementation should also assist hospitals with outstanding underpayments by fully reimbursing them for the services provided. Also, faster final settlements with hospitals should remove the disincentive they have toward participating in Medicaid in States with large amounts of outstanding underpayments.

IMPLEMENTATION AS OF DECEMBER 1, 1975, OF SECTIONS OF THE SOCIAL SECURITY AMENDMENTS OF 1967 (P.L. 90-248) HAVING COST CONTROL ASPECTS

Summary Table

Purpose of Section	Sections of Law
Modify methods for reimbursing providers	None
Increase share of cost borne by beneficiary	None
Reduce unneeded utilization	237
Change benefits or eligibility criteria	220
Emphasize use of more cost effective providers	224
Improve management to eliminate over-payments, abuses, and fraud	None
Reduce administrative costs	129,130
Strengthen Federal administration	None
Other	229,302(a)

Sections 129 and 130:	Provided that all hospital outpatient services would be covered under the Supplemental Medical Insurance program. Effective April 1, 1968.
Implementation:	Regulations were published on August 25, 1971.
Intent:	Before enactment of these sections, hospital outpatient services were paid under part A if they were diagnostic in nature and part B if they were not. A $20 deductible applied to part A coverage and a $50 deductible to part B coverage. By covering all hospital outpatient services under part B, administration for the program was simplified for the Government, the providers and the beneficiaries. This simplification should help hold down administrative costs and ease confusion over covered benefits for providers and beneficiaries.
Section 220:	Provided that the upper limit for eligibility for Medicaid as a medically needy person be 133 1/3 percent of the cash assistance standard for the aid to families with dependent children program in the State. With several exceptions, effective June 30, 1968.
Implementation:	Regulations were published on January 28, 1969.
Intent:	The Congress believed that some States were including people under the Medicaid program as medically needy persons whose incomes were high enough to cover their medical expenses. The upper limit on incomes was therefore established to control the number of eligibles and thus total Medicaid costs.
Section 224:	Provided that home health care services must be included in the Medicaid program for any individual who is entitled to skilled nursing home services under the State plan. Effective July 1, 1970.

Implementation: Regulations were published on June 24, 1969.

Intent: The Congress wanted to be sure that home health services would be available to Medicaid patients who needed them so that they would not have to be institutionalized. The cost of home health services is generally less than the cost of institutional services so use of home health services should save money. GAO has reported on the home health care benefit under Medicaid and the problems associated with its implementation. (See p. 82.)

Section 229: Provided that States must take all reasonable measures to determine if a third party has a legal liability to pay for care provided to Medicaid recipients. Effective April 1, 1968.

Implementation: Regulations were published on January 17, 1969.

Intent: The Congress wanted to ensure that if any third party was liable to pay for medical expenses incurred by Medicaid eligibles those third parties would pay for the services and not Medicaid. HEW has not helped the States establish systems to obtain payment of medical costs from liable third parties, and has not established reporting requirements to enable it to monitor and evaluate the effectiveness of State third party recovery programs. States have widely varying programs to avoid or recover Medicaid costs from liable third parties.

Section 237: Provided that the States must have a program of utilization review for all services provided under Medicaid.

Implementation: Regulations were published on March 4, 1969.

Intent: The Congress wanted the States to have procedures to protect against unnecessary utilization of services and overpayment for services. GAO has issued a number of reports on the weaknesses in these State procedures. (See pp. 65, 69, 72, 74, 79, and 97.)

Section 302(a): Provided that States must have an early and periodic screening, diagnosis, and treatment program under Medicaid for eligible individuals under the age of 21. Effective July 1, 1969.

Implementation: Regulations were published on November 9, 1971.

Intent: The Congress wanted to derive the benefits of preventive medicine for children eligible for Medicaid. The States and HEW were slow to implement this program, so in 1972 the Congress enacted a penalty provision for not implementing it. (See p. 124.) GAO has reported on the deficiencies in implementing this program. (See pp. 92 to 96.)

IMPLEMENTATION AS OF DECEMBER 1, 1975, OF SECTIONS OF THE SOCIAL SECURITY AMENDMENTS OF 1972 (P.L. 92-603) HAVING COST CONTROL ASPECTS

Summary Table

Purpose of section	Sections of Law
Modify methods for reimbursing providers	207(a)(1), 221, 223, 224, 227, 228, 232, 233, 245, 249
Increase share of cost borne by beneficiary	204, 208
Reduce uneeded utilization	207, 235, 237, 238, 249F, 298
Change benefits or eligibility criteria	230, 231
Emphasize the use of more cost effective providers	226, 240
Improve management to eliminate overpayments, abuses, and fraud	229, 236, 242
Reduce administrative costs	239, 246, 262
Strengthen Federal administration	None
Other	234, 299F

Section 204:	Increased the deductible for part B from $50 to $60. Effective January 1, 1973.
Implementation:	Regulations were published on June 3, 1974.
Intent:	Because medical costs had risen considerably since the start of the program, beneficiaries were paying a lower portion of their medical costs. Therefore, the Congress increased the deductible so that part B beneficiaries would continue to bear a reasonably representative portion of their covered medical costs. This action saved Medicare $8 for each part B enrollee who met the new part B deductible. This saved Medicare about $100 million in 1975 plus 80 percent of the amount between $50 and $60 for those enrollees who do not meet the new deductible.
Section 207 and 237:	Provides for a one-third reduction in Federal sharing for the Medicaid costs of providing care beyond 60 days in hospitals, skilled nursing homes, and intermediate care facilities and 90 days in mental hospitals for States which do not implement utilization review programs meeting specific requirements. This section was effective July 1, 1973.
Implementation:	Final regulations were published on November 29, 1974. However, a Federal District Court ruling prohibited HEW from requiring the States to follow certain provisions of the regulations. HEW did not appeal the ruling but instead withdrew these portions of the regulations and is rewriting them to meet the objections in the ruling. The Secretary has informed the Subcommittee on Investigations and Oversight of the House Committee on Interstate and Foreign Commerce that, while he realizes that the law compels him to impose the penalties, he will not do so at this time and is studying alternatives to the penalty provision.

Intent: The reason the Congress passed these sections was to ensure that Medicaid recipients were receiving appropriate care at the appropriate type of facility. Since it is less costly to provide care at a lower level (for example, a nursing home instead of a hospital), ensuring that recipients are not in too expensive a facility would help control Medicaid costs. The impact on providers of care would be closer scrutiny of their decisions to institutionalize recipients. The impact on States would be higher utilization review costs but hopefully lower institutionalization costs. The Senate Committee on Finance estimated that these sections would save $74 million during fiscal year 1973 and $162 million during fiscal year 1974.

Section 207 (a)(1): Provides that there must be a reasonable cost differential between providing care in a skilled nursing home and an intermediate care facility. The Secretary can reduce the amount claimed for Federal sharing in intermediate care facility costs if he determines that a reasonsble cost differential does not exist. This section was effective on July 1, 1973.

Implementation: On April 1, 1975, HEW published final regulations implementing this section. These regulations require the Statewide cost differential to be at least 10 percent unless a lower differential is proven to be reasonable.

Intent: Since intermediate care facilities provide less intensive care than skilled nursing homes, their costs should be lower. The Congress wanted to ensure that the lower costs would accrue to the Medicaid program. The impact on States is that they must pay intermediate care facilities, on the average, at least 10 percent less than they pay skilled nursing homes.

Section 208: Provided that States must impose an enrollment fee, premium, or similar charge on medically needy Medicaid eligibles and that any deductible, cost sharing or similar charge for the categorically needy must be nominal. This section was amended by P.L. 93-368 to make the imposition of enrollment fees, premiums or similar charges optional for the States and not mandatory. The P.L. 93-368 provision was retroactively effective to January 1, 1973.

Implementation: Regulations to implement the P.L. 93-368 provision were published on October 11, 1974.

Intent: The Congress felt that this section would help make Medicaid recipients more cost conscious and therefore reduce overall costs. The amendment changing imposition from mandatory to optional lessened the impact of the section. The impact of the section on Medicaid recipients would be to increase the cost of their medical care in States that imposed premiums or cost sharing.

Section 221: Provided that the Medicare and Medicaid programs would not participate in the costs associated with capital expenditures which were not approved by a State or areawide planning agency as discussed in section 1122 of the Social Security Act. Effective on enactment.

Implementation: This section has not been fully implemented. Proposed regulations were published on September 9, 1974, for Medicaid and on January 1, 1975 for Medicare but final regulations have not been published.

Intent: The Congress wanted to be sure that the Medicare and Medicaid programs would not participate in the costs of unnecessary capital expenditures by health facilities and thereby hold down program costs. The part of this section which calls for approval of capital

expenditures by State or areawide planning agencies has been implemented by regulation. However, neither Medicare nor Medicaid has implemented the parts of the section requiring them not to participate in the costs of unapproved capital expenditures so the expected benefits may not have been fully realized.

Section 223: Provided that under Medicare reasonable cost determinations, only costs that are necessary for the efficient delivery of health services would be recognized. Since hospital cost reimbursement under Medicaid is limited to what Medicare pays, this section also effects Medicaid hospital reimbursements. Effective January 1, 1973.

Implementation: Regulations were published on June 6, 1974.

Intent: The Congress felt that the Medicare and Medicaid programs should not pay for care which was more costly than required for efficient delivery of health care or for services which were not necessary for the efficient delivery of care. The intent of this section was to discourage provision of unnecessary and inefficient services. The impact on providers would be to deny payment for services determined to be unnecessary and to deny payment for that portion of cost determined to be the result of inefficient operations. The impact on program beneficiaries could be that they would have to pay for the costs determined to be unnecessary or inefficient.

Section 224: Provided that for Medicare and Medicaid the overall reasonable charge level for physicians would be limited to the higher of the prevailing charge recognized by the carrier and accepted by the Secretary on December 31, 1970, or the 75th percentile of customary charges and be frozen at the amount determined for fiscal year 1973 except that they could be increased by an amount equal to an appropriate economic index. For medical services, supplies, and equipment that do not generally vary in quality from supplier to supplier,

reasonable charges would generally be limited after December 31, 1972, to the lowest charge level at which they were available in a locality.

Implementation: Physician reasonable charges had been limited by regulation to the 75th percentile of customary charges for Medicaid in June 1969 and for Medicare effective January 1, 1971. Regulations were published on June 16, 1975, implementing that portion of the section freezing charges at the fiscal year 1973 level unless increases are justified on an economic index basis. The portion limiting payment for medical services, supplies, and equipment has not been implemented by regulation.

Intent: The Congress wanted to limit payments to physicians to the 75th percentile of cutomary charges and to increases which could be justified on the basis of economic changes and to limit payments for other medical services, supplies and equipment to the lowest charge in a locality. By holding increases in reasonable charges to these levels the Congress expected to control the costs of the applicable services. Since this section has not been fully implemented, the expected benefits of this section have not been fully realized.

Section 226: Provided that cost based per capita payments could be made by Medicare to health maintenance organizations. Effective July 1, 1973.

Implementation: This section has not been fully implemented by regulations.

Intent: The Congress wanted the Medicare program to derive the benefits of health maintenance organization-like entities for beneficiaries who chose to enroll in such organizations. Some of the benefits which are supposed to be derived from prepayment health plans are more preventive care, better coordination of health care, and less high cost institutional care. Because of such factors, these organizations are supposed to provide care

at a lower overall cost and cost savings could be passed on to Medicare. This section has not been fully implemented by regulation and as of December 1975 no contracts with health maintenance organizations have been entered into.

Section 227: Provided for two methods for paying under Medicare services provided by supervisory and teaching physicians in teaching hospitals: (1) as part of the reasonable cost determination under part A; or (2) on a fee-for-service basis if the beneficiary was a "private patient" of the staff physician or if the hospital established that historically its normal procedure was to bill all patients on a fee-for-service basis for services provided by supervisory and teaching physicians. Effective July 1, 1973. However, under Public Law 93-233 (enacted December 31, 1973) as amended by Public Law 93-368 (enacted August 7, 1974), the requirement that feefor-service payments would be made only where a private patient relationship is established has been deferred until July 1, 1976. This was done so that the National Academy of Sciences would have sufficient time to undertake a study to assess the impact of the teaching physician amendment on teaching hospitals.

Implementation: Regulations were published on August 8, 1975 to cover situations where a hospital elects with the concurrence of its medical staff, to receive reimbursement on a reasonable cost basis between July 1, 1973, and July 1, 1976.

Intent: The Congress wanted to clarify how services provided by physicians in teaching hospitals should be paid and to insure that Medicare was not paying more than it should for such services. (See p. 49 for a discussion of a GAO report on the problems of paying for the services of supervisory and teaching physicians in hospitals under Medicare.) The

extensions of the effective date of the amendment were caused by problems in defining private patients and by complaints concerning the loss of revenues to institutions which could result from its implementation.

Section 228: Provided that the Secretary could establish, by medical conditions and lengths of stay or number of visits, periods for which a patient would be presumed to be eligible for skilled nursing facility or home health care benefits. Effective January 1, 1973.

Implementation: Proposed regulations were published on July 9, 1975. Final regulations have not been published.

Intent: Before enactment of this section, determination of eligibility for skilled nursing home or home health care benefits could not normally be made until after the services had been started. This led to retroactive denials of payments for services which caused financial hardships for both the providers and the beneficiaries. The Congress wanted to ease the problem of retroactive denials by authorizing the Secretary to designate periods of time for specific conditions during which eligibility for benefits would be presumed. The Congress believed this would encourage prompt transfer of patients to less costly types of care, identify in advance points in time where further assessment of medical care needs should be made and end some of the problems of retroactive denials. Since this section has not been fully implemented, the expected benefits may not have been realized.

Sections 229 and 242: Provided criminal penalties, for fraud and false reporting under the Medicare and Medicaid programs (section 242). Section 229 provided authority for the Secretary to suspend payments to providers that made false reports or abused either of the two programs. Effective on enactment except for suspension of payments under Medicaid which was effective January 1, 1973.

Implementation:	Regulations were published on March 1, 1974.
Intent:	The Congress wanted to include in law a definition of what constituted fraud and false reporting under Medicare and Medicaid and to provide the Secretary with a means of stopping payments to providers who abuse the programs.
Section 230:	Eliminated the provision in the law that required States to move toward providing comprehensive care under their Medicaid programs and in fact to provide such care by July 1, 1977. Effective on enactment.
Implementation:	Not required.
Intent:	The Congress was concerned that requiring States to move toward providing comprehensive care would place a burden on State finances, cause States to cut back in other programs, or discontinue their Medicaid programs. Therefore, this section was enacted and the requirement was dropped.
Section 231:	Repealed the provision in the Medicaid law which required States to expend at least as much on their Medicaid programs as they had the prior year. Effective on enactment.
Implementation:	Not required.
Intent:	The Congress felt that the repealed section might lead to fiscal crises in some States and also that it restricted the flexibility of States in designing their Medicaid programs and in meeting crises. The House Committee felt that the repeal would save $570 million during fiscal year 1973 and $640 million during fiscal year 1974. However, the Senate Committee felt it would only save $70 million and $40 million during the two fiscal years because of the effect of other sections of the law.
Section 232:	Provides that States could establish under their Medicaid programs methods for paying for inpatient hospital services on a reasonable cost basis which differ from Medicare

methods but do not result in payments which exceed those determined under the Medicare program. This section was effective July 1, 1972.

Implementation: Prior to July 1971, HEW required States to use Medicare hospital cost reimbursement principles. The Secretary then allowed States to develop other principles on a demonstration or experimental basis. Section 232 embodied this practice in law on an operational basis. On August 6, 1974, HEW published regulations implementing this section. The regulations stipulate that States must use either the Medicare method or a method which provides for (1) incentives for efficiency or economy, (2) reimbursement on a reasonable cost basis, (3) assurance that an adequate number of hospitals will participate in Medicaid, (4) adequate documentation for evaluation of the method, and (5) payments which do not exceed Medicare reasonable cost determinations.

Intent: Several States felt that the Medicare standards resulted in payments for Medicaid patients in excess of reasonable costs. The Congress provided the States flexibility in their cost determination methods by enacting this section.

Section 233: Provides that, for services paid for on a reasonable cost basis by Medicare, payment will be made at the lower of reasonable costs or customary charges. The section also applies the same rule to inpatient hospital services paid for by Medicaid. Effective January 1, 1973.

Implementation: Regulations for Medicare were published on May 10, 1974, and for Medicaid on August 6, 1974.

Intent: For the services covered by this section, Medicare and Medicaid will not reimburse providers for more than their customary charges even if their reasonable costs are higher.

Section 234: Provided that medical institutions, as a condition for participation in Medicare, would be required to have a written overall plan and budget reflecting an operating budget and a capital expenditure plan. Effective 5 months after enactment.

Implementation: Regulations were published on January 17, 1974.

Intent: The Congress felt that some institutions had inflated costs because they lacked an adequate planning and budgeting process. The impact on providers of this section is that it forces them to have a planning and budgeting process in order to participate in Medicare.

Section 235: Provides that the Federal Government will share at increased rates in the design, development and installation (90 percent) and operation (75 percent) of Medicaid mechanized claims processing and information retrieval systems. The section also provides for 90 percent Federal sharing in the costs of designing, developing, and installing cost determination systems for State-owned general hospitals. Retroactively effective for expenditures after June 30, 1971.

Implementation: Regulations published on May 20, 1974, with explanatory program guidelines issued on June 10, 1974.

Intent: The Congress believed that by increasing Federal financial participation in the design, installation, and operation of Medicaid mechanized claims processing and information retrieval systems and increasing Federal technical assistance to the States in this area, the overall management of the Medicaid program would be enhanced and cost savings realized.

Section 236: Provided that payments to providers for services under Medicare or Medicaid could not be made to anyone except the individual providing the services unless that person is an employee of another or has an agreement with the facility where the service was provided to submit claims for him. Effective on enactment for Medicare and on January 1, 1973, for Medicaid.

Implementation: This section was implemented by regulation for Medicare on January 31, 1974, and for Medicaid on April 9, 1974.

Intent: Experience had shown that practitioners were assigning their payment rights to others and that this was resulting in incorrect and inflated claims. The Congress was attempting to control this practice. However, in some instances, the intent of the law has been circumvented by practioners having others--often called factors--submit their claims for them and giving the power of attorney to cash the checks to the factor.

Section 238: Provides that Medicare payments will not be made for inpatient services more than 3 days after the facility has been notified by the peer review committee that, after reviewing an admission, the admission or continued stay in the facility, is not medically warranted. Effective 2 months after enactment.

Implementation: Regulations were published on January 17, 1974.

Intent: Medicare will not reimburse medical facilities for patients determined by a peer review committee after reviewing admissions that the inpatient stay is not warranted. This should encourage providers to only admit patients in need of institutional services and thus lower program costs. If the patient is not discharged he might be liable for paying the provider.

Sections 239 and 246:	Provided that the same State agency would establish and maintain standards for health facilities for Medicare and Medicaid and that the standards established for skilled nursing facilities must be the same for both programs. The same State agency would also certify health facilities for both programs. The State health agency would be responsible for reviewing the appropriateness and quality of care provided to Medicaid recipients by health facilities. Effective January 1, 1973, except for the common standards provision which was effective July 1, 1973.
Implementation:	Regulations were published on January 17, 1974, and supplimented on October 10, 1974, for the common standard setting and certifying State agencies and on November 29, 1974, for the review of appropriateness and quality of care.
Intent:	The Congress wanted to avoid duplication in institutional standard setting and certification. It also believed that the efficiency and economy of the Medicaid program would be enhanced through the development of the capability in each State to perform utilization review, set standards for quality of care, and review the quality of care provided to recipients. Since only one agency would be responsible for setting standards and certifying facilities and since the standards must be the same for both programs, it would make the process simpler for facilities.
Section 240:	Provided that States could waive the Statewideness of the benefits provision of Medicaid to enable enrollment of recipients in prepayment type medical groups. Effective on enactment.
Implementation:	Regulations were published on May 10, 1974.

Intent:	States can use prepaid type medical groups, even if they provide benefits beyond those in the State plan, to serve Medicaid recipients and the Congress believed that use of these groups could help reduce Medicaid costs.
Section 245:	Authorized the Secretary to conduct reimbursement experiments designed to eliminate unreasonable expenses resulting from prolonged rentals of durable medical equipment. Also authorized, the Secretary to implement on a nationwide basis any reimbursement procedures found by these experiments to be workable, desirable and economical. Effective on enactment.
Implementation:	No experiments have been initiated and no changes in the reimbursement procedures have been made as of December 1, 1975.
Intent:	The Congress enacted this section in response to GAO's report on rental of durable medical equipment when purchase would have been more economical. (See p. 29.) The Congress believed that more economical methods of providing Medicare beneficiaries with durable medical equipment could be devised so it authorized the Secretary to study alternatives to rentals and implement the alternatives he found acceptable.
Section 249:	Provided that, under Medicaid, States must establish skilled nursing facility and intermediate care facility payment rates on a reasonable cost-related basis. Also provided that generally Medicare could pay skilled nursing facilities at the same rate as the State did for Medicaid. Effective July 1, 1976.
Implementation:	This section of the law is not yet effective and, therefore, has not been implemented.
Intent:	The Congress felt that some facilities were being overpaid by Medicaid while others were being underpaid. It hoped to rectify this by passing this section. The Congress

	also sought to lessen the administrative burden on facilities by allowing Medicare to use the State-developed Medicaid rates for payment.
Section 249F:	Provided for the establishment of a system of professional review of the necessity for and quality of services provided under Medicare and Medicaid. These reviews are to be conducted by Professional Standards Review Organizations (PSROs).
Implementation:	This section required the Secretary to designate PSRO areas for the Nation by January 1, 1974. The Secretary designated 203 PSRO areas on March 18, 1974. The section also requires the Secretary to enter into an agreement with a qualified organization whereby the organization is designated as a conditional PSRO as soon as possible after designating the PSRO areas. As of November 13, 1975, the Secretary had 79 planning contracts with organizations to plan to become PSROs and agreements with 63 conditional PSROs.
Intent:	The Congress wanted to be sure that only medically necessary and appropriate health services were provided to Medicare and Medicaid recipients. This section of the law is presently being implemented and several years will be required before all of its impacts on the two programs and their providers and beneficiaries can be assessed.
Section 262:	Provided that at least $100 must be involved before a part B beneficiary could request a fair hearing. Effective on enactment.
Implementation:	Regulations published on April 3, 1974.
Intent:	As estimated 45 percent of hearings held before enactment involved an amount less than $100. The cost of a fair hearing sometimes exceeded $100. This section would reduce administrative costs of the part B program. The impact on beneficiaries is that they cannot have a hearing for small claims.

Section 298: Provided that independent professional review would be required in all intermediate care facilities. Effective on enactment.

Implementation: This section was implemented by regulations published on January 17, 1974. The requirements for independent professional review were published on November 29, 1974.

Intent: Independent professional review is a form of utilization review which should ensure that Medicaid recipients are receiving appropriate care at the proper facility.

Section 299F: Provides for a penalty of 1 percent of Federal aid to families with dependent children sharing money for States which fail to inform eligible individuals about the availability of the Medicaid early and periodic screening, diagnosis, and treatment program for children under 21. States must also arrange for screenings and treatment of conditions uncovered during screening and diagnosis. Effective July 1, 1974.

Implementation: Regulations were published on August 2, 1974.

Intent: The Congress believed that the prevention and early detection of illness in children could produce significant cost savings for Medicaid and also reduce the suffering of eligible children. In order to obtain these benefits the Congress amended the Medicaid law in 1967 to require States to provide screening, diagnosis, and treatment of eligible children under 21. (See p. 29.) GAO has issued a report dealing with the implementation of the program and made a number of recommendations for improvement. (See pp. 92 to 96.) Because of slow implementation of the program the Congress enacted this section to encourage the States to fully implement the program. As of December 1, 1975, nine States had been penalized under this section but all are appealing the penalties and none have yet lost Federal cost sharing.

ADMINISTRATIVE COSTS OF CLAIMS PROCESSING UNDER THE MEDICARE AND MEDICAID PROGRAMS

Medicare

The administrative costs per claim for SSA part B carriers remained relatively stable between fiscal years 1970 and 1975. During the period fiscal year 1968 through fiscal year 1975, administrative costs per claim increased about 50 percent (average annual rate of about 6 percent) for SSA contract intermediaries.

About 70 percent of SSA's direct administrative expenses 1/ for Medicare represent payment to the intermediaries and carriers for claims processing services. These payments have received considerable congressional attention and there is data available to review such costs in historical perspective on a reasonable comparable basis.

The following table lists the average costs per claim processed for the intermediaries and carriers for fiscal year 1968 through 1975.

Average Cost Per Claim

Fiscal year	Intermediaries with audit	Intermediaries without audit	Carriers
1968	$3.82	$2.98	(a)
1969	4.93	3.46	(a)
1970	6.34	4.06	$3.16
1971	6.10	4.44	3.28
1972	6.33	4.52	3.18
1973	6.50	4.82	3.23
1974	6.18	4.83	3.23
1975	5.90	4.72	3.21

a/Not available.

Medicaid

Data is not available to determine the average administrative cost per claim processed.

1/The expenses of other components of HEW, the Treasury Department, the Civil Service Commission and the Railroad Retirement Board are also charged in the Medicare Trust Funds.

PRINCIPAL HEW OFFICIALS

RESPONSIBLE FOR ADMINISTERING

ACTIVITIES DISCUSSED IN THIS REPORT

	Tenure of Office	
	From	To
SECRETARY OF HEALTH, EDUCATION, AND WELFARE:		
F. David Mathews	Aug. 1975	Present
Caspar W. Weinberger	Feb. 1973	Aug. 1975
Frank C. Carlucci (acting)	Jan. 1973	Feb. 1973
Elliot L. Richardson	June 1970	Jan. 1973
Robert H. Finch	Jan. 1969	June 1970
Wilbur J. Cohen	Mar. 1968	Jan. 1969
John W. Gardner	Aug. 1965	Mar. 1968
ASSISTANT SECRETARY FOR HEALTH:		
Theodore Cooper	Feb. 1975	Present
Charles C. Edwards	Mar. 1973	Feb. 1975
Richard L. Seggel (acting)	Dec. 1972	Mar. 1973
Merlin K. DuVal, Jr.	July 1971	Dec. 1972
Roger O. Egeberg	July 1969	July 1971
Philip R. Lee	Nov. 1965	Jan. 1969
COMMISSIONER OF SOCIAL SECURITY:		
James B. Cardwell	Sept. 1973	Present
Arthur E. Hess (acting)	Mar. 1973	Sept. 1973
Robert M. Ball	Apr. 1962	Mar. 1973
ADMINISTRATOR, SOCIAL AND REHABILITATION SERVICE:		
Don I. Wortman (acting)	Jan. 1976	Present
John A. Svahn (acting)	June 1975	Jan. 1976
James S. Dwight, Jr.	June 1973	June 1975
Francis D. DeGeorge (acting)	May 1973	June 1973
Philip J. Rutledge (acting)	Feb. 1973	May 1973
John D. Twiname	Mar. 1970	Feb. 1973
Mary E. Switzer	Aug. 1967	Mar. 1970