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Statement of Elmer B. Staats

Comptroller General of the United States

Before the

Subcommittee on Oversight and Investigations

House Committee on Interstate and Foreign Commerce

HSE02305

[Comments on ~~Report Entitled~~

"Health Costs Can Be Reduced by Millions of Dollars if Federal Agencies Fully Carry Out GAC Recommendations" (HRD80-6

HRD-80-6) November 13, 1979]

AGC00005 DOD
AGC00022 HEW
AGC00160 PHS
AGC00016 VA

Mr Chairman and members of the Subcommittee, we are pleased to be here today to discuss the cost containment implications of our report "Health Costs Can Be Reduced by Millions of Dollars if Federal Agencies Fully Carry Out GAC Recommendations" (HRD-80-6; November 13, 1979).

The Congress is concerned about the ever increasing costs of the Government's health programs. We share these concerns. The Covernment spends vast amounts related to

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health care. The President's budget for fiscal year 1981 estimates that over $59 billion in Federal funds will finance health services rendered to the elderly and disabled under Medicare, the poor under Medicaid, and active duty and retired Federal civilian and military personnel and their dependents. Another $10.5 billion will provide health services to persons eligible under the direct delivery systems of the Departments of Defense and Health, Education, and Welfare and the Veterans Administration. An additional $5.5 billion will finance health-related grant and contract programs administered by HEW's Public Health Service. Many of these programs, such as Community Mental Health Centers, Migrant Health Centers, and Family Planning Clinics help provide needed resources and/or pay for services rendered to eligible persons. Others, such as Health Maintenance Organization and health planning programs are aimed at controlling overall health costs by developing lower cost alternative delivery systems or preventing unnecessary expenditures.

Over the years we have devoted a considerable amount of effort to looking at the administration and effect of the Government's involvement in health care. In our reports we have made many recommendations for actions by the Congress or executive branch agencies which would reduce or dampen increases in health costs. Some of these actions were taken

in whole or in part. Others were not. In the interest of stimulating the Congress and/or the agencies to take a fresh look at those recommendations which had not been implemented or fully implemented, and at the conditions which lead us to make those recommendations, we developed the report we will be discussing today.

Eighty-four of our reports on health programs issued from January 1974 through December 1978 contained 262 cost-saving recommendations. The Congress or responsible Federal agency fully or substantially implemented 98 of these recommendations and millions of dollars have been saved. However, the other 164 recommendations had been only partially implemented or not implemented at all. If the Congress and the agencies implement these recommendations, additional millions would be saved.

Overview of Cost-Saving Recommendations

In the direct delivery health programs most of our recommendations were aimed at

--preventing the construction or purchase of unneeded or oversized health facilities and equipment, and

--getting the various Federal agencies directly providing health services to share resources whenever feasible, thereby eliminating or preventing unnecessary duplication.

For the health financing programs, our recommendations have generally been directed at assuring that

--providers are not overpaid for the services they render,

--program fraud and abuse are identified and controlled, and

--the States and contractors administering the programs comply with Federal laws and regulations.

Our recommendations on the PHS grant and contract health programs were in the main designed to

--improve the efficiency of grantees and contractors so that they could lower or contain the costs of providing services, and

--improve the effectiveness of the programs.

The Congress and the Federal agencies have implemented many of these cost-saving recommendations. A few examples in the areas of the Subcommittee's interest are:

--The number of beds planned for Indian Health Service facilities in the Navajo area was reduced by 296, saving $8.4 million in construction funds and $2.8 million in annual operating costs.

--The Congress amended the Medicare law to provide incentives to patients with end-stage renal disease

to dialyze at home and to remove a disincentive toward receiving a kidney transplant. Based on 1972 data, home dialysis was about $15,000 a year less costly than facility dialysis, and kidney transplants saved about $30,000 a year per patient over facility dialysis.

--Over $1.3 million in Federal funds was recouped in Medicare and Medicaid duplicate payments to a large, publicly owned nursing home.

--The Congress amended the law to control non-arms-length dealings among Health Maintenance Organizations and those who own or control them.

--Detection of lead poisoning through increased screening was strengthened. This should result in preventing cases of mental retardation and save the cost of treating patients.

However, the Congress and the Federal agencies need to take actions to fully implement other recommendations so that additional savings can be realized. Again, a few examples will illustrate what could be accomplished:

--There is a need for greater sharing of health resources among the direct health delivery systems of the Departments of Defense and Health, Education, and Welfare and the Veterans Administration. Every 1-percent

reduction in these systems' costs, achieved by sharing, would save taxpayers about $100 million.

--When nursing home beds are unavailable to Medicare and Medicaid patients, they stay in more costly hospital beds. Data indicate that about $73 million in Ohio and about $216 million in New York is being spent on hospital services for such patients who could be served adequately by nursing homes if beds were available.

--About $53 million could be saved in fiscal year 1981 if States were permitted to award contracts competitively for Medicaid laboratory services.

--Payments to States for Medicaid administration should be based on performance standards. This would provide States with incentives to increase controls over fraud, abuse, and waste which should generate large savings in program costs.

--Improvements in deinstitutionalizing the mentally disabled would save the Government millions.

Mr. Chairman, your February 11, 1980, letter expressed particular interest in three of the reports covered in our follow-up report. We will now address the cost saving potential available from fully implementing the recommendations

in those reports.

Medicaid Expenditures for Ineffective or Possibly Effective Prescription Drugs, B-164031(2); February 15, 1974

In December 1970 the Surgeon General requested all HEW agencies to prohibit the use of Federal funds for drugs which the Food and Drug Administration had classified as ineffective or possibly effective. In 1972 we reported to HEW that States were expending substantial amounts under Medicaid for such drugs and recommended that Federal sharing for these expenditures be prohibited. In 1974 we again reported substantial Medicaid expenditures for ineffective and possibly effective drugs (estimated at $8.3 million annually for just three States) and repeated our recommendation. It has been over 9 years since the Surgeon General's request, almost 8 years since our first recommendation, and 6 years since our second recommendation. There is still no prohibition against using Federal funds to pay for these drugs under Medicaid.

Prohibiting Federal sharing in Medicaid expenditures for ineffective and possibly effective drugs should in most, if not all, States result in these drugs not being covered by Medicaid. This in turn should result in the prescribing of drugs which have evidence of effectiveness rather than drugs with little or no evidence of effectiveness. The health

care of Medicaid recipients would be improved and, hopefully, the costs of treating them for the condition which the drug did not help would be reduced.

Preventing Mental Retardation--
More Can Be Done, HRD-77-37;
October 3, 1977

Of the many causes of mental retardation, we selected seven inherited metabolic disorders which can be detected by analyzing a newborn infant's blood and treated to prevent retardation. We wanted to see how effective early screening programs were operating because prevention of mental retardation results in avoiding the costs of care and education of the retarded by such programs as special education, rehabilitation services, and Medicaid. Also preventing mental retardation saves lives and avoids human suffering.

We found that most States had a program for testing a blood sample from newborn infants to detect one of the inherited metabolic disorders--phenylketonuria or PKU. Although improvements were needed in many of these PKU screening programs to reach all newborns, much of the benefits were being realized. However, only a few States were screening for six other inherited metabolic disorders which can cause mental retardation--maple syrup urine disease, homocystinuria, galoctosemia, tyrosinosis, histidnemia and hypothyrodism. All of these disorders can be tested for by

using the same blood sample and can be screened for little or no additional cost if automated laboratory methods are used on a large scale.

We estimated that the costs of screening all newborn infants for the seven disorders and treating those identified would be about $18.5 million a year. On the other hand, about $437 million in costs of caring for those who would become retarded without screening would be avoided. On a discounted basis, this represents a cost/benefit ratio of $8.70 saved for each $1 expended. In addition, the lives of at least 50 children would be saved each year.

We recommended that HEW (1) evaluate State screening programs to identify those which are not effective and provide necessary assistance, (2) encourage and support expansion of newborn screening to include treatable metabolic disorders in addition to PKU, and (3) encourage and assist States to cooperate to establish cost-effective regionalized metabolic screening programs.

HEW is working on the recommendations and has encouraged the States to expand their newborn screening programs and it awarded 21 screening grants and a grant to Colorado to establish a regional screening program. HEW will need to continue to encourage and assist the States with their newborn screening

programs. Until the recommendations are fully implemented, there will continue to be the loss of lives or unnecessary costs of care and treatment from a lack of detection of metabolic disorders.

This report also dealt with efforts to prevent mental retardation associated with prematurity and low birth weight, chromosone abnormalities, rubella and measles, lead poisoning, RH hemolytic disease, and early childhood environmental conditions. We found weaknesses in preventive efforts in all these areas and made recommendations to improve prevention efforts. Additional actions by HEW are still needed on several of these recommendations.

Attainable Benefits of the Medicaid Management Information System Are Not Being Realized, HRD-78-151; September 26, 1978

In the early 1970s HEW developed and espoused the benefits of a model Medicaid Management Information System (MMIS) in facilitating the payment of provider claims under that program. In 1972 the Congress increased the Federal sharing rate for these systems to 90 percent for development and installation and 75 percent for operation. We reviewed three HEW approved MMISs and found them to be underdeveloped, under used, and not in compliance with all legal requirements for increased funding.

MMISs are supposed to provide the States with the information necessary to manage their Medicaid programs and control program fraud and abuse as well as accurately pay for legitimate claims. Because of weaknesses in HEW's approval process, State MMISs were being approved for increased Federal sharing even though they did not meet all requirements. Also, HEW could not effectively monitor or control State administrative costs because of the lack of data on such costs.

The Surveillance and Utilization Review subsystem of an MMIS provides the main benefits over and above those of a good claims processing system. The review subsystem should provide information that (1) assesses the level and quality of care provided to Medicaid recipients and (2) identifies and facilitates the investigation of suspected instances of fraud or abuse by Medicaid providers and recipients.

The review subsystem had not accomplished either of its purposes effectively. It was underdeveloped, ineffective in identifying potential misutilization, and of unproven value. States generally were not reviewing the quality of care provided Medicaid recipients as required, and the subsystem was not providing the data needed to help States do so. Overall, States were using a trial and error approach in using the subsystem and its reports.

We made a number of recommendations to HEW to improve

its MMIS approval process and take action which should result in improved State MMISs. HEW established a Task Force to look at MMIS and HEW told us the Task Force would consider our recommendations.

Overall, we concluded that Federal sharing in State administrative costs should be based on how well the State performs, not on whether or not it has an approved MMIS. We recommended that the Congress amend the law to so provide. The Senate has passed a provision, as an amendment to the Adoption Assistance and Child Welfare Act of 1979 (H.R. 3434), which would implement this recommendation as well as put into law many of the recommendations we made to HEW. We support this provision. H.R. 3434 is currently with a conference committee.

RECENT REPORTS IMPACTING ON HEALTH COST CONTAINMENT

The Subcommittee also asked us to discuss three recent GAO reports which could have an impact on health care cost containment.

Hospitals in the Same Area Often Pay Widely Different Prices for Comparable Supply Items, HRD-80-35; January 21, 1980

At the request of the Chairman of the Subcommittee on Health of the Senate Finance Committee, we surveyed the

prices paid for about 40 items by various hospitals in six major cities. The cities were Atlanta, Cincinnati, Columbus, Miami, Pittsburg, and Seattle.

We found wide differences in the prices paid for the same or comparable items. For example, in Seattle one hospital paid $2.42 for a cylinder of oxygen while another paid $5.37. In Cincinnati one hospital paid $3.19 for irrigating solution while another paid $1.17. In Pittsburgh one hospital paid $4.20 for a roll of instrument recording paper while another paid $1.12. In Atlanta one hospital paid $1.22 for a flourescent lamp while another paid $.59.

Overall, there was at least a 100 percent price difference between the highest and lowest price for 22 percent of the items where comparisons could be made.

The most frequent plausible explanation was that hospitals do not share price information and, thus, were not aware when they were paying more than another institution for the same item.

HEW and its Medicare intermediaries had devoted scant attention to the costs of items routinely purchased by hospitals because they believed such activities would not be cost effective.

Recognizing that regulatory or monitoring activities by the Government or its contractors result in some added costs,

we analyzed the price data, as well as the annual volumes purchased, to identify those high-dollar high-volume items where the potential dollar savings appeared to be the greatest.

Although the number of items meeting this criteria varied from city to city, we identified five such items which offered substantial potential savings for hospitals in at least two of the cities. Total savings for these five items for the hospitals surveyed would be about $150,000 annually. Because our review was limited to less than one-half of one percent of the hospitals participating in the Medicare program, it is likely that potential savings for these five items alone could amount to millions of dollars.

Accordingly, we proposed that HEW instruct its intermediaries to gather price information on the five items and communicate such information to the hospitals they service to facilitate the exchange of price information.

HEW agreed, in part, with our recommendations; however, before it issued instructions to all intermediaries, HEW wanted to conduct an experiment with at least one intermediary.

Need to Better Use The Professional Standards Review Organization Post-Payment Monitoring Program HRD-80-27; December 6, 1979

Professional Standards Review Organizations--PSROs--are organizations of practicing physicians designed to assure

that health care services, provided under Medicare and Medicaid, are delivered as efficiently and economically as possible--principally in hospitals. PSROs review the medical necessity and appropriateness of inpatient admissions and length of stay and prospectively deny payment for medically unnecessary care.

Over the past several years, considerable emphasis and study has been given to the question of whether this activity can function effectively as a cost containment mechanism. In other words, is the $150 million spent to finance PSRO activities offset by reduced Medicare or Medicaid utilization?

While there have been disagreements as to the methodologies to be used in answering this question, it is clear that only a 1 or 2 percent reduction in Medicare hospital utilization can be an important factor in determining the cost effectiveness of PSROs.

Prior to the implementation of the PSRO program, Medicare fiscal intermediaries, such as Blue Cross, reviewed hospital claims for medical necessity. Although the PSROs assumed the responsibility for determining medical necessity for payment purposes, under the post-payment monitoring program the intermediaries randomly sample and review 20

percent of the claims related to the inpatient admissions reviewed by a PSRO. The intermediary's doctors identify any disagreement with the PSRO determinations. According to HEW, the objectives of the post-payment monitoring program are (1) to provide an educational tool to assist PSROs in fulfilling their responsibilities, and (2) to assist HEW in evaluating how effectively PSROs are functioning.

In our December 1979 report to the Secretary, we pointed out that the post-payment monitoring program was not working as intended primarily because HEW had not issued guidelines or instructions on how the program should work.

For the four PSROs we visited, where intermediary findings could be related to total Medicare inpatient days, the intermediaries questioned the necessity of 1 to 5 percent of the days approved by the PSRO and officials at two of the four PSROs agreed that they had incorrectly approved 2.6 percent and 4.2 percent of the days as necessary when they were not.

As previously mentioned, a relatively small reduction in Medicare hospital utilization can be an important factor in making the PSRO cost effective. We believe that the post-payment monitoring program could be a more useful tool to PSRO and HEW management for improving the PSRO program and we recommended that HEW issue instructions specifically on

how the program should be used to meet this objective.

Pennsylvania Needs an Automated System to Detect Medicaid Fraud and Abuse, HRD-79-113; Sept. 24, 1979

Because Pennsylvania did not have an automated claims processing and information retrieval system, Medicaid fraud and abuse could go undetected in the State. The State relied on manual claims processing to pay many of its Medicaid claims. This process was not able to systematically detect claims for ineligible persons, duplicate claims, inappropriate charges, or whether a third party, such as an insurance company, was liable for paying the claims. The manual process relied on the ability of the claims processors to remember fee schedules and prior claims in order to assure proper payments. Also, HEW estimated that, on the average, a claims processor had only about 5 seconds to process a claim.

Pennsylvania's utilization review program was primarily a manual operation--18 employees manually reviewed a 5-percent sample of provider invoices and subjectively selected providers to profile. Because the staff members review only a 5-percent nonrandom sample, an unknown number of program abusers escape detection. From January to March 1979 the staff reviewed over 141,000 invoices and recouped about $446,000 through provider repayments and prepayment claims adjustments. Much

of what the reviewers do manually on the 5-percent sample could be done automatically on all claims by an automated claims processing and information retrieval system. We concluded that the State needed such a system.

Senator Schweiker who requested our review introduced a bill, S.731, which would provide incentives to States to develop automated systems. The bill also would implement many of the recommendations made in our MMIS report which we discussed earlier. The Senate adopted a modified version of this bill as an amendment to the Adoption Assistance and Child Welfare Act of 1979, H.R. 3434. The version of H.R. 3434 passed by the House did not include this provision. Conferees have been appointed, but as of March 3, 1980, had not met.

ADDITIONAL GAO EFFORTS RELATED TO COST CONTAINMENT

I would like to discuss two recent efforts relating to hospital cost containment in general and Federal Medicaid costs in particular.

Hospital Cost Containment Efforts

The rapid rate of increase in hospital costs has and continues to be one of the most serious problems confronting the Nation. While many factors contribute to this rapid

cost growth rate, many economists contend that since hospitals are removed from the normal economic factors of the marketplace, much of the incentive for hospital managers to operate their institutions efficiently is minimized. Many also agree that the traditional cost-based retrospective method of paying for hospital services has eroded any remaining cost reduction incentive by essentially paying the cost of whatever medical treatments are deemed appropriate by physicians and hospitals.

Many States, in fact 27, have attempted to modify the way in which hospitals are paid by adopting programs under which payments are based on rates determined before the services are provided. These programs, usually called prospective ratesetting programs or prospective payment programs, are designed to help control rising hospital costs by providing an external authority to establish or review the prices that hospitals may charge and/or that third parties and private payors are required to pay for specified services. These State programs vary in their authority to control hospital payment rates with some being required by law while others are voluntary. Either type can have the authority to determine or alter payment rates or can be merely advisory.

Recently we conducted a review to determine the impact of prospective ratesetting programs and found that generally,

when compared with the national average, States with such programs were more successful in controlling the rate of cost increases. States with programs applicable to all hospitals and with the authority to determine or alter hospital rules had the greatest success with growth rates averaging several percentage points lower than the national average.

We also examined the extent to which hospitals across the country have implemented selected management techniques that could restrain hospital cost increases, such as patient preadmission testing, admission scheduling, energy conservation techniques, use of generic drugs, and nurse scheduling systems. We sent a questionnaire to a national sample of 2,800 hospitals and conducted case studies of hospitals claiming significant cost reduction impact from using one or more of the cost containment management techniques.

Over 80 percent of the hospitals surveyed responded and the results indicate that hospital managers nationwide have not generally implemented many of the management techniques that could significantly restrain hospital cost increases. Even in States with a prospective ratesetting program there was little difference in the extent of hospital implementation of the management techniques compared to the level of implementation in cost-reimbursement States. Our case studies

documented significant cost savings resulting from use of many of the management techniques.

Our report is currently with HEW and others for comment and should be issued in final form by June 1 of this year.

States Are Not Effectively Identifying and Recovering Medicaid Overpayments and Returning the Federal Share

We recently completed a review of State efforts to identify and recover Medicaid overpayments and return the Federal share. We were concerned that large amounts of Federal funds were being tied up because of a lack of or ineffective State procedures in this area. We found that the five States reviewed (California, Florida, Georgia, New York, and South Carolina) had identified at least $222 million in substantiated or potential overpayments which had not been collected. Many of these overpayments had been outstanding for several years. Thus, the overpaid providers have had, in effect, interest-free loans of Federal and State money. In addition, because the States are years behind in their audits (which are the primary means of identifying overpayments), millions more in overpayments have probably not been identified. These overpayments become harder and harder to recover the older they get.

We also found that the five States had recovered about $18.7 million in Medicaid overpayments for which they had

not returned the Federal share on a timely basis. Sometimes States had held this cash for years without returning the Federal share. In other cases, States were periodically returning the Federal share of collected overpayments but their procedures for doing so were so slow and cumbersome that large amounts were continuously outstanding. Moreover, States usually deposited recovered funds in interest-bearing accounts but were inconsistent in sharing interest earned with the Federal Government.

On several occasions during our review, we reported our findings pertaining to these cash accounts to HEW's Health Care Financing Administration. HCFA took positive and timely efforts to resolve the reported issues for the particular States we visited. Furthermore, HCFA took the approach we used and told its regional offices to review all the States. HCFA's review is not complete but as of January 1980 it had recouped $41.9 million in Federal Medicaid funds from 14 States--principally representing excess cash. In addition it was in the process of recouping another $39.2 million from 8 States--which principally represented the Federal share of old unrecovered overpayments.

The preponderance of HEW's regulations and policy guidance supports the view that the Federal share of Medicaid

overpayments should be refunded immediately after being identified--although as a matter of practice the States wait until collections are made which often takes years. We believe HEW should recoup the Federal share from the States for such overpayments when they are identified, unless the States demonstrate that their overpayment recovery systems are effective and in conformance with HEW standards. We made recommendations for designing such standards.

This concludes my statement. We will be happy to answer any questions you may have.