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UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

HUMAN RESOURCES
DIVISION

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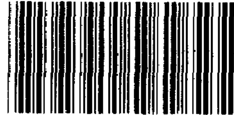

JULY 20, 1982

The Honorable Richard S. Schweiker
The Secretary of Health and Human Services

Dear Mr. Secretary:

Subject: Waiver of Medicaid Freedom-of-Choice Requirement: Potential Savings and Practical Problems (GAO/HRD-82-90)

Medicaid recipients have been free to obtain health care services from any qualified provider they choose. The authorizing legislation guaranteed this "freedom of choice." Section 2175 of the Omnibus Budget Reconciliation Act of 1981 (Public Law 97-35), however, added to the Social Security Act section 1915, which authorized you to grant the States waivers of the freedom-of-choice provision for inpatient hospital services and other services. The regulations implementing section 2175, effective on October 1, 1981, provide that, in applying for a waiver, the State Medicaid agency must document the (1) cost effectiveness of the project, (2) effect on recipients regarding access to care and quality of services, and (3) projected impact of the waiver.

To explore the hypothesis that restricting freedom of choice for hospital services would reduce costs without affecting access to or quality of care, we made some cost comparisons in Maryland and Georgia and believe the results will be of interest to you. In Maryland for example, for 17 selected nonemergency procedures, the data show that Medicaid savings of nearly $1.6 million could possibly have been realized in calendar year 1979 in the city of Baltimore. How much of the savings could actually be realized would depend on the extent of physician and hospital acceptance. We identified similar potential savings and circumstances in the Atlanta, Georgia, area.

The results of our analysis follow. Additional information is included in enclosures I (Georgia) and II (Maryland).

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OBJECTIVES, SCOPE, AND METHODOLOGY

Because of Medicaid fiscal problems, some States have supported the elimination of freedom of choice for Medicaid recipients. The idea is that health costs could be reduced if only lower cost providers furnished the medical services. We initiated our review to determine if savings could be achieved and to identify the practical problems that may be encountered if freedom of choice were eliminated and lower cost providers furnished the services.

Maryland was selected for our study because its Health Services Cost Review Commission, in a letter to the Senate Finance Committee staff, supported the provision to amend Medicare and Medicaid freedom of choice to allow payers either to direct patients to a less costly provider or to give patients incentives to select more efficient providers. In addition, they strongly supported allowing Government agencies to selectively contract with efficient health care providers. Also, the Commission has a data base on hospital charges. Georgia was selected because the State recently modified its Medicaid reimbursement system and one of the approaches it considered was the exclusion of high cost hospitals.

Our analysis focused on hospitals in metropolitan Atlanta and Baltimore. These areas accounted for a large portion of the Medicaid expenditures in the States and have many hospitals. We looked at the metropolitan areas because they offered the maximum potential for savings.

Regarding quality of care, we only considered hospitals currently licensed by the State to provide service and certified by the State to participate in Medicaid. We assumed such hospitals would be able to provide care at an acceptable level of quality.

Various ways can be used to identify the most efficient providers and to limit the number of providers from whom beneficiaries can obtain services. We tested two alternative methods to identify low cost hospitals. Diagnoses related groups 1/ were used to identify low cost hospitals in the Atlanta area, and surgical and delivery procedures were used in the Baltimore analysis. In both locations savings were computed on the basis that five or more hospitals would provide the service.

1/A diagnoses related group is a set of individual diagnoses that are expected to be similar in the type and extensiveness of services required for treatment. Therefore, the expectation is that the costs to treat these diagnoses will be similar.

In computing potential savings, we excluded Maryland hospital admissions classified as "emergency" 1/ which in the Baltimore area accounted for about one-third of the total Medicaid caseload. In Georgia, the data base did not distinguish emergency admissions, and accordingly, we did not consider this in our potential savings estimate.

In Maryland the potential cost savings are based on an analysis of charge data that are required to be reported by hospitals to Maryland's Health Services Cost Review Commission. The Commission is an independent body which, among other things, is responsible for setting rates for individual Maryland hospitals that are applied to all the hospitals' claims, including Medicaid. Each hospital is required to submit to the Commission various claim information, including diagnosis, surgical procedures, and charges. For Medicaid patients, the State pays the charges less a 6-percent discount.

In Georgia, the potential cost savings are based on an analysis of a special hospital reimbursement data base developed and maintained by the Georgia Department of Medical Assistance. The claims included in the data base were obtained from the State's Medicaid Management Information System and were coded according to 383 diagnoses related groupings.

In developing the potential cost savings, we essentially used charge data in the existing data bases and, as noted above, excluded where we could certain hospital admissions that could affect the potential savings. There are other factors that could affect the potential savings which could not be developed through the data bases used to make our analysis. The following describes some of these other circumstances that could affect the savings:

--Transportation costs could increase if Medicaid beneficiaries were required to travel longer distances to obtain hospital care.

--Professional fees for services, such as anesthesiology and radiology, could affect the estimated savings depending on whether such charges are included in the hospital billing or are billed separately by physicians. If high cost hospitals generally include charges for these services in their

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1/In Maryland, emergency admissions are defined as those required within 24 hours of request. While a portion of the emergency admissions would allow sufficient time for a patient to go to a low cost hospital, for estimating purposes, we assumed that all emergency admissions required immediate medical attention.

hospital claims and the low cost hospitals do not, the potential savings would be less. The savings would be greater if the opposite is true.

--The savings would be overstated to the extent of increases in the cost per unit of service at hospitals where Medicaid cases are reduced. Such increases can occur because decreased occupancy and utilization rates increase the costs for the other Medicaid patients. This same effect could affect other payers, such as Medicare.

We discussed the practical problems that may be encountered in shifting Medicaid patients with a number of affected parties, including Maryland and Georgia State officials, Professional Standards Review Organization officials, and selected hospital officials and physicians. Our work was performed in accordance with the Comptroller General's current standards for audit of governmental organizations, programs, activities, and functions. Additional information on our scope, methodology, and study limitations is discussed below and in the enclosures.

ESTIMATES OF POTENTIAL SAVINGS

Baltimore

Our estimate of $1.6 million in potential Medicaid savings for the Baltimore area represents about 1.8 percent of the inpatient charges of 17 Baltimore City hospitals for 1979 and 1.2 percent of the inpatient charges for all Maryland hospitals. The estimate is based on the analysis of 13 high volume surgeries (such as hysterectomies and tonsillectomies) and four classifications of deliveries. These 17 procedures--which are classified as nonemergency admissions--represented about 12 percent of the total charges by the Baltimore hospitals.

Potential savings were computed for each of the 17 procedures by first determining an overall average charge for the five lowest charge hospitals. The savings were then calculated on the assumption that the procedures performed at the high cost hospitals would be performed at one of the five low cost hospitals at a charge approximating the average charge. A total of five hospitals was selected judgmentally in light of the following considerations: first, the fewer the number of low cost hospitals chosen, the greater the likelihood that the hospitals would not have sufficient capacity to absorb the caseload from the high cost hospitals, and second, the greater the number of hospitals, the smaller the savings that can be realized.

Atlanta

We computed potential savings of about $1.7 million (including emergency admissions) in the Atlanta area using a different methodology than used for Baltimore.

In the Atlanta analysis, we used diagnoses related groups instead of procedures in a two-step process to compute the $1.7 million savings. In the first step, we identified what appeared to be the seven most costly hospitals by comparing the cost of their cases to the other hospitals. In the second phase of this analysis, we determined the savings if the approximately 3,000 cases the seven high cost hospitals had reported would have been transferred to any of the 10 other hospitals at the weighted average cost of the 10 hospitals.

Emergency cases in the Atlanta universe were not excluded because they could not be readily identified. As a result, the $1.7 million Medicaid savings would likely be significantly less if emergency type cases were excluded. About one-third of the 39,000 cases in the Baltimore analysis were coded as emergency.

Atlanta was quite different than Baltimore. One hospital was dominant in Atlanta reporting over half of the cases and the volume of cases admitted to the 17 hospitals in the Atlanta area was much less than in the Baltimore area, 13,000 and 39,000 cases, respectively. Also, by way of comparison, 9 of the 17 Baltimore hospitals reported 2,000 or more Medicaid cases, while each of 12 Atlanta hospitals reported 406 or fewer cases. The $1.7 million represents about 7.4 percent of the inpatient charges of 17 Atlanta area hospitals and about 1.6 percent of the inpatient charges for all of Georgia.

PHYSICIAN AND HOSPITAL ACCEPTANCE

In the Atlanta area, hospital officials said they would accept some additional Medicaid patients, but they did not want to significantly increase their Medicaid patient loads. Baltimore hospitals were more willing to increase their Medicaid loads. In both areas, there was concern about physician participation in the program primarily because of low Medicaid reimbursement rates.

Several Atlanta hospital officials said they would not want to be designated Medicaid hospitals or increase their proportion of Medicaid patients. They said designation, as a Medicaid hospital, is an irreversible stigma that would cause other patients to seek care elsewhere. Also, the hospitals did not want to significantly increase the proportion of Medicaid patients because Medicaid generally pays less than other third-party payers.

Atlanta area hospital officials and physicians said physician participation in the Medicaid program could be affected if hospital participation is restricted. They said physicians who want to extend their practice to the designated Medicaid hospitals may not be able to because of hospital policies and requirements related to physician admitting privileges. They were also concerned about the time and travel involved as a result of practicing at several hospitals and the comparatively low Medicaid reimbursement rates.

Some Baltimore area hospital officials said they were willing to accept more Medicaid patients; however, one hospital pointed out that it was concerned about the financial implications of increased Medicaid caseloads due to factors, such as government payment limitations and Maryland's 20-day limitation on hospital stays. Other officials said physicians with admitting privileges may not be willing to increase their Medicaid caseloads because of low Medicaid fees. One official said that physicians may object to increasing their proportion of Medicaid patients. He said some physicians may impose limits on the number of Medicaid patients they will treat.

Other comments relative to restricting freedom of choice of Baltimore Medicaid recipients are discussed in enclosure II.

LIMITED INFORMATION REQUIRED TO OBTAIN WAIVER

The regulations implementing the waiver of the freedom-of-choice provision require States to document the (1) cost effectiveness of the project, (2) effect on recipients regarding access to care and quality of services, and (3) projected impact of the program. However, the regulations do not specify what kinds of data and/or analysis should be considered in documenting these areas. Our Baltimore and Atlanta analyses identified a number of issues that could affect these areas if freedom of choice for hospital services were to be restricted, including

- --the size of the geographic area covered by the waiver,
- --the impact of including teaching hospitals,
- --the impact on physician participation in Medicaid,
- --the willingness of hospitals and physicians to participate in a waiver, and
- --patient access to hospitals offering specialized services.

We also believe that similar kinds of issues could arise under waiver requests for other types of restrictions on recipients' freedom of choice. Thus, guidance on the types of information needed to document the requirements imposed on the States should be beneficial to them in designing waiver requests.

We noted that the conference report for the Omnibus Budget Reconciliation Act of 1981 (H.R. 97-208) stated that regulations should be issued as soon as possible so that the States will have guidance concerning the standards you will apply concerning waiver requests. Current regulations contain little guidance.

Eight States have submitted 11 requests asking you to waive requirements of section 1902(a)(23) of the Social Security Act which permits Medicaid recipients to select the provider of their choice. Most of the States have also requested waivers to section 1902(a)(1) which requires the State plan to be in effect throughout the State.

Many of the eight States requested the waivers under section 1915(b)(1) of the Social Security Act which permits you to waive requirements of sections 1902 and 1903(m) as may be necessary for a State to implement a case-management system that restricts the providers from whom an eligible Medicaid recipient can obtain primary care services in other than emergency circumstances. The case-management systems proposed varied by State; however, the Medicaid recipient would generally obtain health care services through health maintenance organizations, prepaid health plans, or specified fee-for-service physicians. As of June 30, 1982, your Department had approved six waiver requests submitted by five States where case-management systems were proposed. Two other State requests for waivers involving case-management systems were being reviewed at that time. Three additional States requested authority to waive the freedom-of-choice provision involving services to a specific group of recipients, such as a case-management system for patients overutilizing services and the restriction of psychological services to mental health clinics. As of June 30, 1982, the three requests were being reviewed.

A Health Care Financing Administration official said that she was not aware of any waiver requests that deal specifically with hospitals.

CONCLUSIONS

Restricting a recipient's freedom of choice for nonemergency hospital services could potentially result in significant Medicaid savings. However, practical problems associated with implementing

such restrictions could substantially erode savings or have other unwanted impacts on the program. Restricting freedom of choice for other types of services could have similar problems and impacts. Current regulations contain little guidance on the standards your Department will apply in evaluating whether State requests for waivers of recipients' freedom of choice meet the requirements contained in the law. Further guidance on this should assist States in planning for and preparing waiver requests and also help ensure the requirements of the law permitting such waivers are met.

RECOMMENDATION

We recommend that you provide additional guidance to States on the information necessary to show compliance with the law for waivers to limit freedom of choice of Medicaid recipients.

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

Copies of this report are being sent to the appropriate congressional committees; the Director, Office of Management and Budget; the Administrator of the Health Care Financing Administration; and other interested parties upon request.

Sincerely yours,

Gregory J. Ahart
Director

Enclosures - 2

GEORGIA

BACKGROUND

For fiscal year 1981, Georgia spent $520 million for various Medicaid medical services, of which about $132 million was spent for inpatient hospital services. We reviewed data for 17 hospitals in the Atlanta area to determine what savings might be attained if Medicaid patients were required to use low cost hospitals.

The 17 Atlanta area hospitals are located inside or near the expressway that circles Atlanta. All 17 hospitals are located in Fulton or DeKalb counties. We selected only the hospitals in these two counties because both are served by the metropolitan area transit system and many recipients reside in these counties.

The data base used for our analysis is contained in the Georgia Medicaid Management Information System which was developed and is maintained by the Georgia Department of Medical Assistance.

Inpatient hospital claims for calendar year 1980 were used to make the analysis. However, not all claims during the latter part of 1980 were included because they had not been entered into the data base at the time we obtained the records. The number of cases and billed charges for each of the 17 hospitals are shown in the following chart.

Number of Cases and Charges by Atlanta Area Hospitals (Calendar Year 1980)

Hospital	Cases		Billed charges for covered services	
	Number	Percent of total	Amount	Percent
Atlanta	258	1.9	$ 411,108	1.8
Crawford W. Long Memorial	1,146	8.6	2,516,718	10.9
Decatur	84	0.6	79,887	0.3
DeKalb General	381	2.9	507,478	2.2
Doctors Memorial	131	1.0	314,582	1.4
Emory University	406	3.1	1,736,380	7.5
Georgia Baptist	840	6.3	1,824,057	7.9
Grady Memorial	6,887	52.0	9,167,977	39.7
Metro Eye & Ear	59	0.4	70,740	0.3
Northside	197	1.5	477,680	2.1
Piedmont	200	1.5	347,284	1.5
Shallowford Community	104	0.8	204,955	0.9
South Fulton	360	2.7	569,942	2.5
S.W. Community	991	7.5	1,305,347	5.7
St. Joseph-Fulton	242	1.8	838,311	3.6
W. Paces Ferry	312	2.4	1,239,365	5.4
Physicians and Surgeons	651	4.9	1,476,027	6.4
Total	13,249	a/99.9	$23,087,838	a/100.1

a/Does not add to 100 percent due to rounding.

Over one-half of the cases were reported by one hospital. Twelve of the hospitals reported 406 cases or fewer, and 4 hospitals reported between 650 and 1,150 cases.

Because Georgia's Medicaid program reimburses on the basis of cost, one of the first steps we performed was to convert the charge data to cost. This step was accomplished by applying to the charge data Medicare's cost to charge ratio for these hospitals. The Medicare cost to charge ratio was used because a State Medicaid official said that audits of all providers had not been completed and suggested that use of the Medicare factor would provide a good approximation of the costs.

For the Atlanta analysis, we used diagnoses related groups (DRGs). Cases classified by DRGs have similar medical characteristics and require similar hospital resources. For example, DRG 278 identifies seven procedures used for normal deliveries. Included are episiotomy and procedures for inducing or assisting delivery, such as low and mid forceps.

Initially, there were 13,249 Medicaid cases in our 17 hospital universe; however, it was reduced to 10,701 cases for two reasons. First, all cases in each DRG which varied by more than two standard deviations from the mean cost of the DRG were excluded from the analysis. This was done to exclude cases that may distort the average due to severity of the case, improper classification, or the reporting of incomplete costs. Second, we excluded all cases from a DRG where sufficient information was not available for proper classification.

SAVINGS

Potential savings of about $1.7 million might have been achieved if Medicaid patients were required to use designated low cost providers. The $1.7 million represents about 7.4 percent of the inpatient charges of the 17 Atlanta hospitals and about 1.6 percent of the inpatient charges for all of Georgia. We used a two-step process to estimate the savings.

First, we identified low and high cost hospitals by comparing the cost of the cases they reported with the cost of similar cases treated by other hospitals. For example, hospital A reported 531 cases in 162 DRGs. All providers treated 6,196 cases in these 162 DRGs at an actual cost of about $8.1 million. If hospital A had treated the 6,196 cases at the hospital's average cost, the projected costs would have been about $10.7 million or about $2.6 million higher than the actual costs. By this process, we identified 10 hospitals whose projected costs were lower than actual costs and 7 hospitals where the projected costs exceeded the actual costs.

In the second step, we computed the weighted average cost for each of the DRG cases treated by the 10 low cost hospitals. These 10 hospitals treated 7,370 cases in 295 DRGs. All 17 hospitals treated 10,557 cases in these same DRGs. The actual cost of the 10,557 cases was $14.3 million. The projected cost for the 10,557 cases, assuming they were performed at the weighted average cost at the 10 lower cost hospitals, would have been $12.6 million, thus producing a savings of $1.7 million.

MARYLAND

BACKGROUND

The Maryland Medicaid program spent about $396 million in fiscal year 1980, of which about $170 million (or 43 percent) was for hospital inpatient services. The inpatient expenditures were made to hospitals in Maryland, the District of Columbia, and other States.

The Maryland Health Services Cost Review Commission was created in 1971, and it approves the rates for each of the hospitals in the State. The rates are established for patient care centers, such as medical/surgery and obstetrics and ancillary services (e.g., radiology and drugs). The rates apply to all classes of patients in the hospital, including Medicaid and Medicare patients.

Hospitals in Maryland are required by the Commission to report certain inpatient data on each discharged patient. Each hospital is responsible for (1) preparing the abstract information that includes data items, such as diagnosis, surgical procedures, and charges, and (2) forwarding the information to the Commission. To estimate savings, we used the Commission's data base for calendar year 1979 which was the most current year available when we started our analysis.

Fifty-one hospitals in Maryland reported Medicaid charges amounting to $131.7 million for 69,543 cases in 1979. The following chart shows the charges and number of cases by the Professional Standards Review Organization (PSRO) area:

1979 Maryland Medicaid Cases and Charges

PSRO area	Number of cases	Percent	Charges	Percent
1	4,415	6.4	$ 3,972,823	3.0
2	38,907	56.0	90,642,821	68.8
3	4,409	6.3	6,905,473	5.2
4	7,621	11.0	13,347,566	10.1
5	5,120	7.4	6,841,043	5.2
6	4,111	5.9	4,722,709	3.6
7	4,960	7.1	5,242,836	4.0
Total	69,543		$131,675,271	

The above includes Medicaid charges and cases for a limited number of recipients from other States and the District of Columbia. It does not include all Maryland Medicaid charges since some Medicaid patients go to hospitals in the District of Columbia and in other States.

About 69 percent of the charges ($90.6 million) relating to 56 percent of the cases (38,907) were reported by 17 Baltimore City hospitals in PSRO area 2 which basically consists of Baltimore City. Given the significance of the expenditures in PSRO area 2 and its relatively small geographical area, we believed it was a good place to analyze the savings that might be achieved by limiting free choice.

The number of Medicaid cases, total charges, the average charge per case, and the rankings of the 17 Baltimore hospitals in PSRO area 2 are as follows:

Medicaid Case and Charge Data
For Baltimore City Hospitals
(1979)

Hospital	Cases Number	Cases Percent	Total charges	Percent	Average charge	Average charge rank
Johns Hopkins	8,274	21.27	$23,899,855	26.37	$2,889	1
University of Maryland	4,743	12.19	12,792,408	14.11	2,697	4
Provident	4,262	10.95	10,800,074	11.91	2,534	7
Sinai	2,758	7.09	5,007,741	5.52	1,816	14
South Baltimore General	2,507	6.44	3,779,739	4.17	1,508	16
Baltimore City	2,424	6.23	5,855,486	6.46	2,416	8
Maryland General	2,405	6.18	4,979,450	5.49	2,070	11
Mercy	2,206	5.67	3,582,122	3.95	1,624	15
Union Memorial	2,071	5.32	3,905,866	4.31	1,886	13
Bon Secours	1,844	4.74	4,276,229	4.72	2,319	9
St. Agnes	1,656	4.26	2,394,176	2.64	1,446	17
Church	1,264	3.25	2,888,154	3.19	2,285	10
Lutheran	1,174	3.02	3,005,129	3.32	2,560	6
North Charles	544	1.40	1,563,810	1.73	2,875	2
Children's	290	.75	590,484	.65	2,036	12
Good Samaritan	264	.68	744,227	.82	2,819	3
Kernan	221	.57	577,871	.64	2,615	5
Total	38,907		$90,642,821			

Of the approximately $90.6 million for inpatient services, about $41.6 million (or 46 percent) was excluded from detailed analysis because the admissions were classified as emergencies. Also, another $7.6 million (or 8 percent) was excluded because a surgical procedure or diagnostic test was not reported for the admission. Included here were DRGs for psychiatric disorders and alcoholism, and there was wide variability in the cost for these diagnoses, within and between hospitals.

Of the remaining $41.4 million, we selected for detailed analysis 4 delivery and 13 surgical procedures that had high volume and high total charges. The charges for the 17 procedures amounted to $11.3 million (or 12 percent) of the total inpatient charges for the 17 hospitals. The total charges, number of cases, and number of days of hospitalization associated with these procedures is shown below.

Charges and Days of Care by Type of Procedure

Delivery (note a)	Total charges	Number of cases	Number of days
Low forceps with episiotomy	$1,594,825	1,074	3,729
Other manually assisted delivery	1,009,942	706	2,229
Episiotomy	2,412,087	1,617	5,109
Low cervical cesarean section	2,731,583	914	7,342
Other Procedures			
Hemorrhoids	150,505	92	609
Abdominal Hysterectomy	884,269	275	2,656
Vaginal Hysterectomy	293,322	118	962
Cholecystectomy	508,572	163	1,760
Local excision of lesion of breast	148,448	137	412
Tonsillectomy without adenoidectomy	181,662	185	414
Tonsillectomy with adenoidectomy	230,679	243	494
Adenoidectomy without tonsillectomy	107,977	115	219
Unilateral repair of inguinal hernia	238,954	183	563
Umbilical herniorrhaphy	163,493	127	411
Unilateral salpingo-oophorectomy	154,200	61	491
Bunionectomy	297,969	170	765
Athroplasty of foot and toe	169,655	107	431
Total	$11,278,142	6,287	28,596

a/Included in the charge is an estimated charge for infant care. Separate charges are submitted for the mother's care and that of the newborns.

SAVINGS

Savings were calculated under two alternative approaches: (1) using the five lowest charge hospitals ($1.6 million) and (2) using the five lowest charge hospitals plus the two teaching hospitals ($974,000). Concerning the latter, in its consideration of the Omnibus Reconciliation Act of 1980, the Senate Committee on Finance expressed the view that waiving recipients' freedom of choice should not have an adverse impact on access to medical care in teaching hospitals. Consequently, to estimate what impact this would have on savings, we assumed that the two largest teaching hospitals (Johns Hopkins and University of Maryland) in Baltimore would not lose any patients by limiting freedom of choice.

If the five lowest charge hospitals were used to provide the services, potential savings of about $1.6 million (or about 14 percent) of the total charges for the 17 types of deliveries and surgeries could be achieved. The savings were calculated on the basis that the procedures performed at the 12 higher cost hospitals would be done at the five low cost hospitals at the average charge of the low cost hospitals.

Mercy, St. Agnes, and South Baltimore General hospitals were generally among the five lowest cost hospitals, and most of the time were the lowest, second lowest, and third lowest charge hospitals. Baltimore City, Maryland General, and Sinai were among the five lowest cost hospitals between six and eight times; however, they were more often the third, fourth, or fifth lowest charge hospital. Hospitals, such as Children's, Kernan, and Good Samaritan, did not report any cases in most of the procedures selected for review. Each of these hospitals reported fewer than 300 cases in 1979. Children's and Kernan are classified as children's facilities. Hospitals that reported cases in 10 or more surgeries, but were one of the five lowest cost hospitals in one or no surgeries include University of Maryland, Johns Hopkins, and Provident. University and Hopkins are teaching hospitals. The following chart shows the information relating to this analysis:

Summary Analysis of 17 Procedures by Charge For 17 Baltimore Medicaid Providers (1979)

	Number of times hospital			Number of times hospital was lowest to fifth lowest hospital				
Name of hospital	Did not report cases in the procedures reviewed	Reported cases but was not one of the five lowest charge hospitals	Was one of the five lowest charge hospitals	Lowest	Second lowest	Third lowest	Fourth lowest	Fifth lowest
South Baltimore General	0	1	16	1	7	5	2	1
Mercy	1	2	14	3	2	5	2	2
St. Agnes	3	2	12	7	3	2	-	-
Baltimore City	1	8	8	2	-	1	3	2
Maryland General	1	9	7	-	1	1	-	5
Sinai	3	8	6	-	1	1	3	1
Bon Secours	5	8	4	-	1	-	1	2
Church	5	9	3	-	-	-	1	2
Good Samaritan	12	2	3	2	1	-	-	-
Union Memorial	3	11	3	-	-	-	2	1
Children's	15	0	2	-	1	-	1	-
Kernan	15	0	2	1	-	-	1	-
Lutheran	5	10	2	-	-	1	-	1
Johns Hopkins	1	15	1	-	-	-	1	-
North Charles	7	9	1	1	-	-	-	-
Provident	1	15	1	-	-	1	-	-
University of Maryland	1	16	0	-	-	-	-	-

ENCLOSURE II

If the five lowest charge plus two teaching hospitals had been used to provide the inpatient services, savings of about $974,000 (or 8.6 percent) of total charges for the 17 surgeries could have been achieved. In computing the savings, we assumed that the two teaching hospitals would continue to do the same amount of work as they had reported and the five lowest charge hospitals would do the remainder. The following chart shows savings involved under this approach.

Savings by Type of Procedure

	Savings	Savings as a percent of total charges	Range of average charges
Delivery			
Low forceps with episiotomy	$ 82,360	5.2	$1,227 - $1,969
Other manually assisted delivery	81,229	8.0	1,153 - 1,838
Episiotomy	173,519	7.2	1,148 - 1,917
Low cervical cesarean section	167,173	6.1	2,337 - 3,760
Subtotal	504,281		
Other procedures			
Hemorrhoids	33,034	21.9	814 - 2,721
Abdominal hysterectomy	81,435	9.2	1,757 - 4,825
Vaginal hysterectomy	38,300	13.1	1,871 - 3,748
Cholecystectomy	73,906	14.5	2,020 - 4,613
Local excision of lesion of breast	28,737	19.4	660 - 1,730
Tonsillectomy without adenoidectomy	20,927	11.5	588 - 2,471
Tonsillectomy with adenoidectomy	60,584	26.3	542 - 1,611
Adenoidectomy without tonsillectomy	4,754	4.4	486 - 1,447
Unilateral repair of inguinal hernia	35,926	15.0	746 - 1,973
Umbilical herniorrhaphy	15,242	9.3	1,052 - 2,678
Unilateral salpingo-oophorectomy	20,134	13.1	1,613 - 3,550
Bunionectomy	56,470	19.0	883 - 2,045
Athroplasty of foot and toe	268	.2	1,144 - 2,327
Total	$973,998	8.6	

We discussed with hospital and hospital association officials the practical problems that would affect the savings and implementation of a plan if freedom of choice were limited, and we obtained the following comments:

--In cases involving deliveries, one hospital official said that the hospital would want responsibility for the pre- and post-natal care of the mother and the baby in cases where the mother does not have a primary care physician. The hospital would want to provide the complete service rather than performing the delivery only.

--One hospital official said that most of the Medicaid patients do not have primary care physicians, and most receive such care in the outpatient departments or clinics associated with the hospitals. Officials from one hospital said that they normally undercharge for clinic services; however, if they were required to send the patient to another hospital for inpatient services, they would have to increase their outpatient charges for such services.

--One hospital association official was concerned about quality of care if a patient were required to go to one hospital for one type of surgery or illness and to another for another type of surgery or illness. He said physicians may not be aware of other patient health problems if they were subject to treatment at different facilities for different illnesses.