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

HUMAN RESOURCES
DIVISION

B-211198

AUGUST 16, 1983

The Honorable Margaret M. Heckler
The Secretary of Health and
Human Services

Dear Madam Secretary:

Subject: Medicare/Medicaid Funds Can Be Better Used to Correct Deficiencies in Indian Health Service Facilities (GAO/HRD-83-22)

In 1976, the Indian Health Service (IHS) was authorized to collect payments from the Medicare and Medicaid programs for services provided in its facilities to Indians eligible for these programs. The law required IHS to use the Medicare/Medicaid funds collected to make improvements in its facilities to enable them to meet Medicare/Medicaid standards, and by September 1981 all IHS facilities were in compliance with these standards. IHS now also uses Medicare/Medicaid funds to maintain compliance with the standards.

To encourage its facilities to collect Medicare/Medicaid funds, IHS normally returns Medicare/Medicaid payments to the facility providing the service even though other facilities may have greater needs. This restricts IHS' flexibility in using Medicare/Medicaid funds where most needed. Increased flexibility in using the funds would help improve the overall quality of the services available in the IHS system.

IHS uses an inefficient, costly system to bill and collect from Medicare/Medicaid. In 1982, IHS spent about 9 percent of its Medicare/Medicaid collections on this system, while private hospitals normally spend only 1 to 3 percent. Although there are reasons why IHS' billing and collection system will probably never be as efficient as private hospitals, it, nevertheless, should be made more efficient. Doing so would make more funds available to provide health care.

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BACKGROUND

The Medicare program, authorized by title XVIII of the Social Security Act (42 U.S.C. 1395), became effective July 1, 1966. It is a Federal program which pays much of the health care costs for eligible persons age 65 or older and certain disabled persons. The program is administered by the Department of Health and Human Services' (HHS') Health Care Financing Administration (HCFA).

Medicare consists of two parts. Part A covers inpatient hospital care, skilled nursing facility services, and home health care services. Part A is principally financed by taxes on earnings paid by employers, employees, and self-employed persons. Part B covers, among other things, physician services and outpatient hospital care. Enrollment in part B is voluntary, and it covers physician and other noninstitutional services. Part B is financed by beneficiaries' monthly premium payments and appropriations from general revenues.

The Medicaid program was authorized, effective January 1, 1966, by title XIX of the Social Security Act (42 U.S.C. 1396) and is a Federal/State health program for low-income people. Generally, persons receiving public assistance under the Aid to Families with Dependent Children and Supplemental Security Income programs of the Social Security Act are eligible for assistance under Medicaid. Persons whose incomes or other resources exceed established standards to qualify for public assistance programs but are not sufficient to meet the cost of necessary health care may also be entitled to Medicaid benefits at State option.

Within broad Federal limits, States determine eligibility levels, the scope of Medicaid services offered, and the reimbursement rates for these services. States normally make payments directly to the providers who render covered services to eligible individuals. The Federal Government pays from 50 to 78 percent of the States' costs for health services, depending on States' per capita income, and various rates from 50 to 90 percent of State administrative costs, depending on the function performed. In the case of Medicaid-eligible Indians treated in IHS facilities, the Federal Government reimburses the States 100 percent of the health services costs.

To assure an acceptable level of quality of care under the Medicare/Medicaid programs, HCFA, normally through State health agencies, certifies that Medicare/Medicaid providers comply with certain safety and quality standards, called conditions of participation.

IHS, an HHS component, provides comprehensive health care to Indians and Alaska Natives, primarily through the 48 hospitals, 98 health centers, and several hundred smaller health stations it owns and operates. IHS headquarters, eight area offices, and four program offices in the field administer IHS' direct health care activities.

Before enactment of the Indian Health Care Improvement Act (Public Law 94-437), approved September 30, 1976, IHS facilities, like all other Federal health facilities, were not eligible to receive payments from Medicare or Medicaid. This was based on the principle that the Federal Government was already responsible for paying for care received in Federal facilities. However, Public Law 94-437 made an exception for IHS to the Medicare/Medicaid prohibition against payments to Federal hospitals and enabled its facilities to receive Medicare/Medicaid payments.

WHY IHS WAS GRANTED AN EXCEPTION TO MEDICARE/MEDICAID LAW

Public Law 94-437 authorized resources and provided direction to overcome recognized inadequacies in Indian health care. Title IV of this act authorized IHS facilities to receive payments from the Medicare/Medicaid programs for services provided to Medicare/Medicaid patients. The purpose was to assure Indians access to the quality of care provided to other Medicare/Medicaid beneficiaries. Although Indians are eligible for Medicare/Medicaid benefits in the same manner as other citizens, many Indians reside on reservations served only by IHS facilities which had not met Medicare/Medicaid standards.[1] The Congress approved title IV to provide additional funding to help IHS facilities achieve compliance with Medicare/Medicaid standards, thereby helping assure that Indians have access to quality care at IHS facilities.

The Congress imposed certain conditions on IHS' collection and use of Medicare/Medicaid payments, namely:

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[1]To participate in the Medicare/Medicaid programs, hospitals, nursing homes, and outpatient clinics have to meet certain conditions set out in HHS regulation 42 CFR Chapter IV. The Medicare/Medicaid standards for hospitals are similar to those used by the Joint Commission on Hospital Accreditation, and hospitals accredited by that organization are deemed to meet Medicare/Medicaid standards. In expending the construction and renovation funds authorized by section 301 of Public Law 94-437, HHS was required to assure, whenever practicable, that the facility would meet the Joint Commission standards within 1 year after construction or renovation.

--The House Committee on Interior and Insular Affairs report stated that it was expected that Medicare/Medicaid funds would be used "* * * to expand and improve current IHS health care services and not to substitute for present expenditures." (House report 94-1026, p. 108.) In this regard, title IV states that "Any payment received * * * hereunder shall not be considered in determining appropriations for health care and service to Indians."

--Title IV required IHS to place the payments received in a special fund to be used "* * * exclusively for the purpose of making any improvements * * * [in IHS facilities] * * * which may be necessary to achieve compliance * * * [with Medicare/Medicaid standards and conditions]."[2]

Between October 1, 1977, and September 30, 1982, IHS had collected about $55.7 million in Medicare/Medicaid reimbursement. In fiscal year 1982, about 94 percent of IHS' collections were for treating Medicare/Medicaid patients in IHS hospitals and hospital-operated clinics; the rest was for treatment at IHS' freestanding clinics. Overall, these facilities received about $322 million in appropriated funds and collected about $20 million in Medicare/Medicaid reimbursements in fiscal year 1982.

IHS USED MEDICARE/MEDICAID FUNDS TO ACHIEVE COMPLIANCE

In September 1976, when the Congress passed Public Law 94-437, only about half of IHS hospitals met Medicare/Medicaid standards. In fiscal year 1978 IHS began collecting Medicare/Medicaid reimbursements and identifying ways to spend the collections to bring the remaining facilities into compliance. IHS applied its Medicare/Medicaid funds toward accomplishing this objective, and by September 30, 1981, all of its hospitals and clinics complied with Medicare/Medicaid standards. IHS used Medicare/Medicaid funds primarily to correct staffing and equipment deficiencies and fund maintenance and repair items. IHS officials said that the agency's appropriations are inadequate to provide the needed personnel, equipment, and repairs to maintain compliance with Medicare/Medicaid standards. Therefore, IHS now spends Medicare/Medicaid funds primarily on recurring costs

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[2]The requirement to maintain a special fund for these purposes ceases to apply when the Secretary of HHS determines and certifies that substantially all IHS hospitals and skilled nursing facilities are in compliance. Such a determination has not been made.

needed to maintain compliance. For example, in 1981 IHS paid 417 staff with Medicare/Medicaid funds to correct staff shortages at its facilities. According to IHS officials, the agency needs these employees to maintain Medicare certification standards. The table on the next page shows the historical Medicare/Medicaid fund collections and obligations.

IHS LACKS FLEXIBILITY TO USE MEDICARE/MEDICAID COLLECTIONS WHERE THEY ARE MOST NEEDED

IHS has established a practice that results in the allocation of available Medicare/Medicaid collections to the facility that provided the services rather than redirecting them to its most needy facilities.[3] HHS and IHS officials contend that, because facilities are funded by appropriations, they need the incentive of receiving additional Medicare/Medicaid funds to aggressively pursue patients' eligibility and bill for services. IHS hospitals and clinics have to make greater collection efforts than non-Federal hospitals because IHS patients do not pay for their services and have little incentive to make their eligibility known. While this practice rewards facilities for their collection efforts, it does not assure that the funds will be used where they are most needed to improve Indian health care.

We found that some facilities are able to serve more Medicare/Medicaid patients and thus collect substantial sums, while other facilities collect very little relative to their staffing and facility needs. For example, even though most of IHS' Medicare/Medicaid funds have gone to correct staffing deficiencies, a relationship did not necessarily exist between the amount collected and the staffing needed at the facility. The table on the top of page 7 is intended to illustrate the differences in staffing needs and the Medicare/Medicaid collections for two IHS hospitals and two of the area offices we visited (it is not intended to suggest that these hospitals or offices are those with the greatest staffing needs).

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[3]IHS' policy is to return Medicare/Medicaid collections to the IHS area where they were billed. Generally, IHS area offices follow the practice of returning Medicare/Medicaid collections returned to them to the facilities which generated the bills. Thus, in general, Medicare/Medicaid collections available to a facility are the facility's collections (minus the congressionally required appropriation offset) which have been approved by IHS headquarters for spending to attain or maintain Medicare/Medicaid certification. Unspent collections are carried forward to subsequent years to meet the facility's future needs.

Medicare/Medicaid Collections, Obligations, and Unobligated Balance by Fiscal Year

Fiscal year	Medicare/ Medicaid collections	Obligations					Collections less obligations	Cumulative unobligated balance
		Personnel	Equipment	Maintenance and repair	Direct transfer to appropriations	Total		
1978	$ 2,109,000	-	-	-	-	-	$ 2,109,000	$ 2,109,000
1979	6,599,000	$ 1,346,000	$ 445,000	$1,456,000	-	$ 3,247,000	3,352,000	5,461,000
1980	11,852,000	4,431,000	1,823,000	3,598,000	-	9,852,000	2,000,000	7,461,000
1981	15,308,000	10,078,000	1,682,000	2,429,000	-	14,189,000	1,119,000	8,580,000
1982	19,826,000	8,669,000	1,201,000	1,519,000	$5,000,000	16,389,000	3,437,000	a/12,017,000
Total	$55,694,000	$24,524,000	$5,151,000	$9,002,000	$5,000,000	$43,677,000	$12,017,000	

a/As of July 1983, the unobligated balance was $19,124,000.

Comparison of Direct Services Staffing Needs to Medicare Collections

	Unmet staffing needs--number of positions (note a)	Medicare collections (FY 1982)
Zuni, New Mexico, hospital	54	$ 285,379
Sacaton, Arizona, hospital	122	77,688
Total Albuquerque area	509	1,330,548
Total Phoenix area	1,211	785,655

a/Based on IHS' April 30, 1982, data, which we did not verify.

Although on April 30, 1982, the Phoenix area had more than twice the unmet staffing needs[4] of the Albuquerque area, in fiscal year 1982 Albuquerque received almost twice the Medicare funding as Phoenix. If Medicaid funds were included, the disparity would be even greater because Arizona did not have a Medicaid program at that time.

We also compared facility needs of IHS hospitals to their fiscal year 1982 Medicare/Medicaid collections and found that about one-third of IHS hospitals collected more than the amount necessary to correct all identified facility needs. Other hospitals with far greater needs collected only a small fraction of the amount necessary to correct those needs. The following table is intended to illustrate the disparity between Medicare/Medicaid collections and hospitals' needs, using selected IHS hospitals (it is not intended to suggest that these are the hospitals with the greatest facility needs).

[4]IHS computed these unmet needs by applying a uniform set of standards and criteria designed to identify those locations with the highest level of relative need.

Comparison of Medicare/Medicaid Collections to Facility Needs at Selected IHS Hospitals

Hospitals	Medicare/Medicaid FY 82 collections	Facility needs (note a)
Bethel, Alaska	$573,000	$ 137,000
Zuni, New Mexico	563,000	163,000
Claremore, Oklahoma	834,000	329,000
Phoenix, Arizona (note b)	277,000	2,033,000
Albuquerque, New Mexico	614,000	2,969,000
Sacaton, Arizona (note b)	78,000	1,942,000

a/Based on IHS' March 1982 facility conditions survey. Includes those categories of facility needs that Medicare/Medicaid funds are used to correct (exclusive of staffing and construction needs), such as life and safety code structural deficiencies, maintenance and repair, etc.

b/Arizona did not have a Medicaid program in fiscal year 1982.

IHS USES AN INEFFICIENT, COSTLY BILLING AND COLLECTION SYSTEM

Title IV requires that IHS follow essentially the same Medicare/Medicaid billing and collection procedures as private providers. However, these systems result in a circuitous and expensive method for transferring Federal funds. Also, IHS billing and collection costs were higher than those of private providers because

--the relatively few IHS claims prevent IHS from taking advantage of the economies associated with volume billing and

--the greater number of organizational levels involved in its predominantly manual billing process creates additional work for IHS.

The net effect of IHS' Medicare/Medicaid billing and collection system in fiscal year 1982 was to move about $20 million of Federal funds among four Federal accounts. This transfer of funds cost IHS about $1.8 million to submit its claims.

Medicare/Medicaid billing system costs IHS more than it costs other providers

Public Law 94-437 amended the Social Security Act to provide under section 1880(a)

> "A hospital or skilled nursing facility of the Indian Health Service * * * shall be eligible for [Medicare] payments under this title * * * if and for so long as it meets all of the conditions and requirements for such [Medicare] payments which are applicable generally to hospitals or skilled nursing facilities * * *."

The law also added section 1911 to the Social Security Act which specified the same conditions for IHS facilities to be eligible for Medicaid payments. Therefore, like any other health care provider, IHS prepares claims for each Medicare/Medicaid patient treated.

In fiscal year 1982, IHS spent approximately 94 full-time equivalent staff years on billing and collecting Medicare/Medicaid funds--essentially IHS' only sources of revenue outside its appropriations. Most of these staff years were spent by employees assigned full time to the IHS Medicare/Medicaid collection program. In fiscal year 1982, it cost IHS about $1.8 million, or 9 percent of collections, to collect $20 million of Medicare/Medicaid funds.

In contrast, costs and estimates obtained by HCFA and the American Hospital Association show that private hospitals are much more efficient than IHS in billing and collecting revenue. In 1982, HCFA developed cost estimates in connection with a proposal to change Medicare billing forms. We combined these estimates with other HCFA data and estimated that the costs of submitting bills and maintaining billing records account for less than 1 percent of total private hospital revenue, including Medicare and Medicaid.

Furthermore, 1981 data accumulated by the American Hospital Association on actual costs at 201 hospitals (similar in size to most IHS hospitals) show that about 3 percent of their total costs are spent to administer the entire patient accounting function. These costs encompassed all billing and collection activities needed to collect hospital revenues for treating patients. The costs also include the hospitals' admitting functions, which were not included in the HCFA study. While the patient accounting and admitting functions include costs associated with patient

billing, such as obtaining names of insurance carriers and arranging credit, nonbilling activities, such as scheduling patients' admittance, were also included. Therefore, the 3-percent figure should be viewed as an upside estimate of the cost of billing and collection for private providers.

We noted two reasons why IHS' billing and collection costs were higher than private providers. First, the American Hospital Association data suggest that the volume of billings affects the cost per bill. Cost data from more than 1,700 hospitals accumulated by the Association show that, generally, the number of staff hours needed to prepare and collect a patient's bill decreased when the total number of patients billed increased.

Most IHS hospitals have fewer than 50 occupied beds and prepare bills only for the Medicare/Medicaid program. In fiscal year 1981 only 12 percent of the inpatient days and 3 percent of the outpatient visits at IHS facilities were billed to Medicare or Medicaid. In contrast, private hospitals prepare bills for virtually all patients treated and obtain essentially all their funds through billing for services. Therefore, private hospitals are in a much better position than IHS is to take advantage of the economies that volume billing offers.

The second factor for high IHS billing costs relates to the number of organizational levels involved. In the case of private providers, the billing and collection system is usually centralized. However, in IHS, the facility providing the service, the applicable IHS area office, and IHS headquarters all become involved in the Medicare/Medicaid billing and collection system. This involvement of multiple IHS organizational levels in its predominantly manual Medicare/Medicaid billing and collection system is cumbersome and results in additional work through maintaining duplicate sets of reports and records.

The Medicare/Medicaid billing and collection process in IHS generally starts with the hospital or clinic, which makes inquiries about whether the patients are eligible and, if so, prepares the necessary claim documents for each Medicare/Medicaid patient. The hospital or clinic keeps duplicate copies of the claim document and sends the original and other copies to the IHS area offices. The area office in turn submits all the claims received to either HCFA or the States for payment. HCFA processes Medicare claims, and the States process Medicaid claims as they do for other providers. When the IHS area office receives payment, it reconciles the amount billed with the amount received. The area office notifies each hospital or clinic of the amounts collected for treating patients at that facility. Because IHS

hospitals and clinics have a stake in the funds collected (see p. 9), they also generally reconcile the amounts billed with the amounts received.

The process continues with area offices forwarding receipts through the Federal Reserve System to IHS headquarters, which also maintains its own records on billings and collections. IHS headquarters then notifies each area office of the amount of its collections that can be spent. Area offices in turn notify each hospital or clinic of the Medicare/Medicaid funds that it can spend.

While IHS maintains some computerized statistical data on patients treated, relatively little opportunity existed to use these data to automatically generate Medicaid/Medicare bills. According to IHS data processing officials, no Medicare inpatient claims were being computer generated because the IHS statistical data were not timely and, in most cases, did not include data needed to prepare Medicare bills. Therefore, according to IHS officials, to automate IHS' Medicare inpatient claims processing would require IHS to incur the expense of establishing and maintaining separate data bases on Medicare patients treated. For Medicare outpatient claims, facilities in four IHS area/program offices were using existing automated patient care information to generate claims. However, an area office official at a facility using this automated system said it had not experienced any cost savings because the clerical staff still had to (1) identify eligible patients, (2) verify data accuracy, (3) obtain required signatures, and (4) manually process Medicare inpatient claims.

IHS had worked out agreements with two States to enable it to prepare its Medicaid claims through a computer. This required the IHS area office to obtain a computer tape of all Medicaid-eligible recipients. The computer matches this tape with an IHS computer tape of patients treated and automatically generates Medicaid claims. However, IHS data processing officials, when questioned whether it was practical to extend a standardized computer billing system to the other States, told us that differences in State Medicaid claims processing systems would require IHS to work out individual agreements with each of the other 16 States involved in IHS Medicaid reimbursements.

CONCLUSIONS

The objective of providing IHS with additional resources so that its facilities could comply with Medicare/Medicaid standards has been achieved and, as such, has improved IHS' assurance that quality health care will be delivered in a safe environment. While IHS facilities now comply with these standards, maintaining compliance is an ongoing process requiring continued funding.

IHS' method of distributing Medicare/Medicaid collections to facilities has not assured that the facilities most in need of funds receive them and has resulted in the accumulation of a large unobligated balance of Medicare/Medicaid collections. We agree that facilities need an incentive to bill and collect Medicare/Medicaid funds and that returning collections to the billing facility provides such an incentive. However, this procedure does not assure that the funds are used where most needed. We believe IHS should distribute the unobligated Medicare/Medicaid funds to other facilities. This should result in an overall improvement in the services available in the IHS system.

IHS' Medicare/Medicaid billing and collection system is much more costly than those of private hospitals. Although it probably is not possible for IHS to be as efficient in this area as private hospitals, it should be possible to improve efficiency by eliminating duplicate functions among the various organizational levels of IHS and in some cases by increased automation of the billing and collection system. If billing and collection costs are reduced, additional funds would be available for health care.

RECOMMENDATIONS

We recommend that you direct the Assistant Secretary for Health to revise IHS procedures to allow unobligated Medicare/Medicaid collections to be distributed to IHS facilities with unmet needs.

We also recommend that you direct the Assistant Secretary for Health to increase the efficiency of IHS' Medicare/Medicaid billing and collection system by such means as eliminating duplicative functions among the various IHS organizational levels and increasing automation of the system where justifiable by cost savings.

OBJECTIVES, SCOPE, AND METHODOLOGY

For several years, during the annual IHS appropriations hearings, the Congress expressed interest in IHS' use of Medicare/ Medicaid payments. We wanted to determine how far along IHS was in meeting the primary purpose for which it receives Medicare/Medicaid funds (that is, meeting the Medicare/Medicaid conditions of participation).

We performed our review at IHS headquarters; IHS' Anchorage, Oklahoma City, Phoenix, and Albuquerque area offices; and IHS hospitals in Anchorage, Alaska; Claremore, Oklahoma; Zuni, New

Mexico; and Sacaton and Phoenix, Arizona. At these locations we became familiar with the billing and collection systems and reviewed IHS' procedures to control the use of the funds collected. We discussed Medicare/Medicaid collections and expenditures with officials at all levels and obtained the supporting planning and expenditure documents, including IHS' reports on facilities and staffing needs. We also talked with HCFA officials regarding their role in reimbursing IHS facilities.

Our review was performed in accordance with generally accepted Government auditing standards.

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As you know, 31 U.S.C. 720 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. Under that law, the statement must also be submitted 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.

We are sending copies of this report to the Chairmen of the four above-mentioned committees and the cognizant legislative committees. A copy is also being sent to the Director, Office of Management and Budget, and other interested parties.

Sincerely yours,

Richard L. Fogel
Director