HCFA & Editorial Comment Forum

The *Health Care Financing Administration* (HCFA) was established to combine health financing and quality assurance programs into a single agency. HCFA is responsible for the Medicare program, federal participation in the Medicaid program, the Professional Standards Review program, and a variety of other health care quality assurance programs.

The mission of the Health Care Financing Administration is to promote the timely delivery of appropriate, quality health care to its beneficiaries—approximately 47 million of the nation's aged, disabled and poor. The agency must also ensure that program beneficiaries are aware of the services for which they are eligible, that those services are accessible and of high quality, and that agency policies and actions promote efficiency and quality within the total health care delivery system.

Forum, the official magazine of HCFA, is published to inform a wide audience on all aspects of health care financing and the activities and programs of the agency. Among its readers are health care administrators, planners, and other professionals; state health and health financing agencies; and major public and private corporations, institutions, and associations that finance health care for their members or employees.

Forum provides information on actions and policies that promote efficiency and quality within the total health care system, promoting discussion and debate of the complex issues and problems relating to health care. By soliciting views from outside HCFA and the Department, *Forum* contributes to a constructive relationship and dialogue among the agency and health care providers, third-party payers, and other segments of its readership.

Medicare, Medicaid, hospital standards, the health professions—all show the impact of political, legislative, administrative, and economic forces. In this issue, *Forum* considers just how some of these programs and institutions are evolving.

For an analysis of the activities of the *Joint Commission on the Accreditation of Hospitals, Forum* turned to one source outside HCFA and another within. Once near-adversaries, HCFA and JCAH have joined hands to work toward higher quality hospital care. Of course, standards set by JCAH and HCFA are crucial in assuring Medicare and Medicaid beneficaries the best possible hospital care.

Concerning *Medicare*, is it true what they say about its *trust funds?* HCFA's chief actuary gives you the facts—explaining the complexities of Medicare financing and just why health care providers have an important role in keeping the program financially sound.

On *Medicaid, Forum* has a description of how the program is practicing *quality control* methods common in industry, involving systematic sampling. Such methods help Medicaid find errors in eligibility determination, claims processing, and third-party reimbursement. Armed with this data, federal and state officials can make corrections and save program dollars.

Because the supply of primary care practitioners is finally catching up to the demand, *nurse practitioners and physician assistants* may broaden their perspectives. Learn how, after a decade of learning and rendering primary care, they may turn increasingly to provide medical services to the growing numbers of elderly in institutions, as well as to the mentally ill and handicapped.

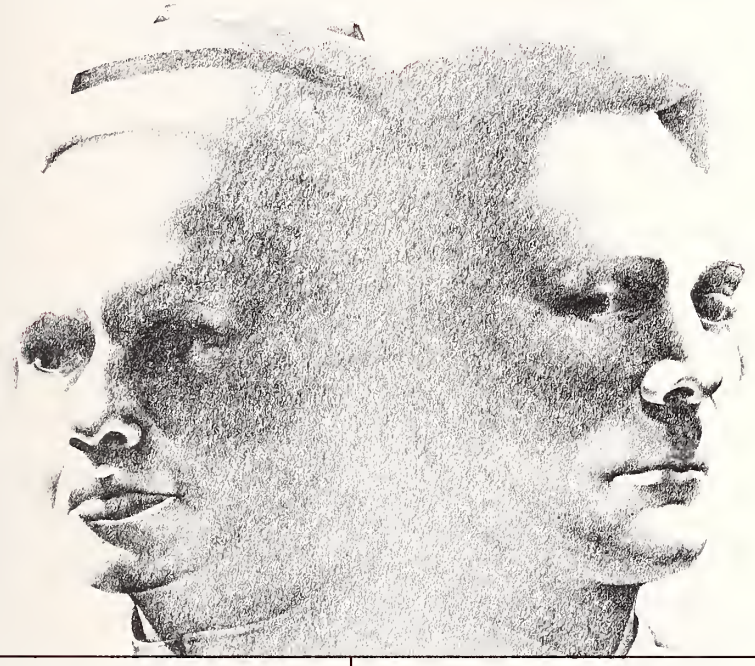
Virginia T. Douglas
Editor

Volume 4, Number 5 Dec 1980

FORUM

Health Care Financing Administration

Articles



What's ahead for nurse practitioners and physician assistants?
by Jerry L. Weston, ScD
Emphasis may change from primary to long-term care for elderly, handicapped, and mentally ill.

Looking for errors in Medicaid
by Carlton Stockton
Quality control techniques are used to save dollars, improve program management.

U.S. Department of Health and Human Services
Patricia Roberts Harris, Secretary

Health Care Financing Administration
Howard N. Newman, Administrator
Barney Sellers, Acting Director
Office of Public Affairs

Virginia T. Douglas, Editor
Doris Simmons, Editorial Assistant

Published by the Health Care Financing Administration, Department of Health and Human Services. Issued bimonthly by the Office of Public Affairs.

Annual subscriptions are $7.50, domestic; $9.40, foreign, and are paid to the Superintendent of Documents, Washington, D.C. 20402. Single copy price is $2.25, domestic; $2.85, foreign.

Address manuscripts to the Editor
Room 648, East High Rise Building,
6401 Security Boulevard
Baltimore, MD 21235
Telephone: 301-594-6821

Publication funds were approved by the Office of Management and Budget on Feb. 25, 1972, amended July 1979. Controlled circulation permit paid at Main Post Office, Washington, D.C. (ISSN 0160-7154)

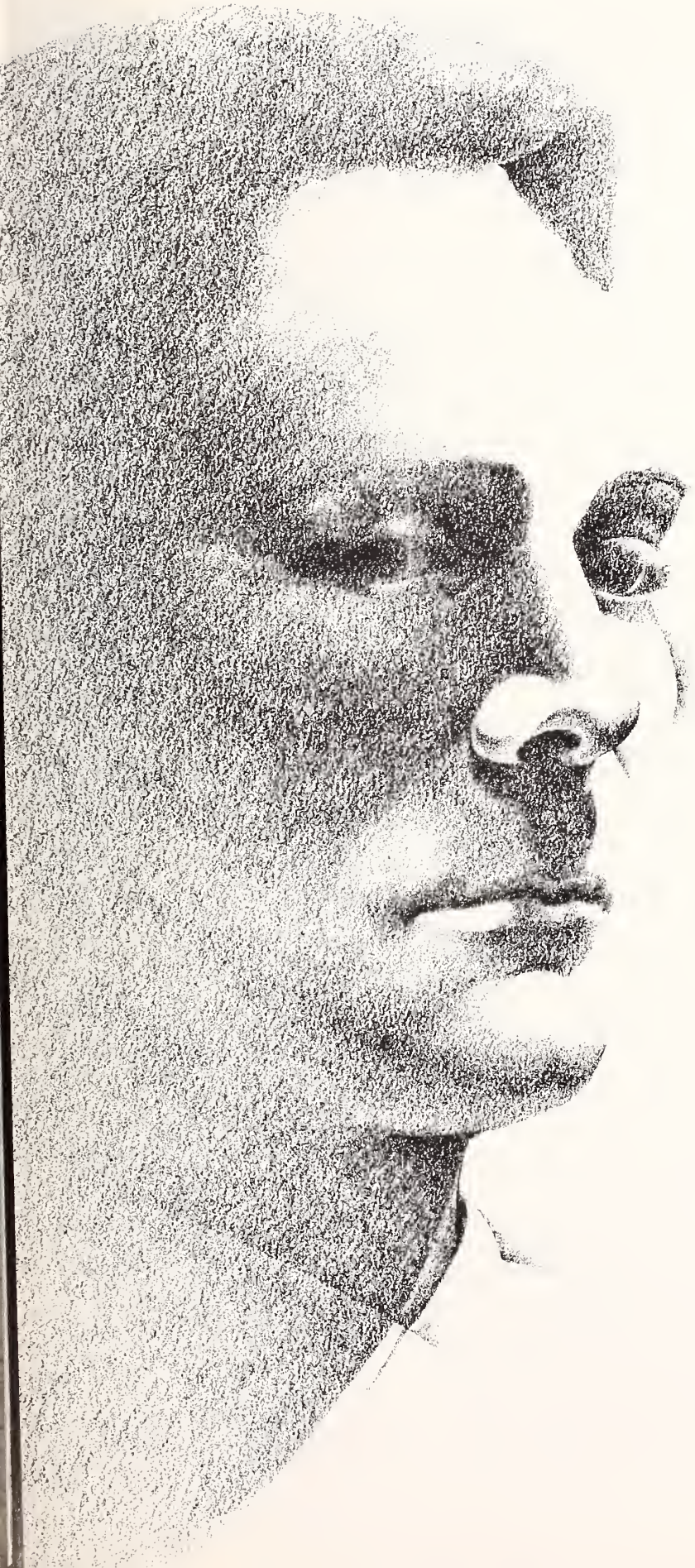
A tale of two trust funds
by Guy King
Medicare funds are solvent now, but costs may outpace tax base.

Putting hospital standards on the examining table
by Howard Wolinsky and Margaret VanAmringe
HCFA and JCAH cooperate in monitoring hospitals to promote quality care.

Departments

What's Ahead for Nurse Practitioners and Physician Assistants?

by Jerry L. Weston, Sc.D.



In the 1960s, residents of many communities across the country lacked access to primary health care, partly because there were too few health professionals trained in it. As a result, the needs of these residents—who were often, but not invariably, rural people—went unmet for such services as:

- Prompt treatment in medical emergencies;

- Timely medical care for serious illness or injury, especially in cases where early attention could prevent the problem from worsening;

- Ready access to a health professional authorized to prescribe needed drugs; *and*

- Pre- and post-natal and well-baby care.

Public policy focused on the problem. One major solution developed was to train increased numbers of health professionals in primary care—not only physicians, but physician assistants (PAs) and nurse practitioners (NPs). There followed in the 1970s a decade of emphasis on such training.

Now, as the United States enters the 1980s with a sizable and growing number of such professionals at work or in training, earlier policies toward primary care are being considered, and new questions are being asked about nurse practitioners and physician assistants:

- How well are they accepted and utilized?

Dr. Weston is senior research manager for manpower in the National Center for Health Services Research, under the Office of Health Research Statistics and Technology, Public Health Service, DHHS. Her Doctor of Science degree was earned at the School of Hygiene and Public Health, Johns Hopkins University. She also holds an MPH from Tulane University and a BSN from JHU.

- Has the availability of NP/PAs increased access to primary health care?

- How can primary health and medical services best be targeted and delivered to segments of the population that need them?

For services they are trained to perform, NPs and PAs deliver care of a quality equal to that of a physician.

- How will NP/PAs likely be utilized in the future?

This article, based on recent data gathered and analyzed by the National Center for Health Services Research of the Public Health Service, discusses the current status of physican assistants and nurse practitioners and attempts to answer these questions.

Usually supervised by physician

The majority of nurse practitioners and physician assistants today are primary care practitioners, in association with a physician or physicians. This association may be on-site or, in some cases, at a site remote from the physician's location of practice. The PA functions under the general supervision of the physician, while the NP requires supervision for medical management, but not for nursing practice.

Basic functions of both physician assistants and nurse practitioners are to:

- Take medical histories and perform physical examinations to define health and medical problems;

- Institute therapeutic regimens within established protocols and recognize when to refer the patient to a physician or other health care provider: *and*

- Provide counseling to individuals, families, and groups concerning health promotion and maintenance.

As in the past, the issues surrounding utilization of nurse practitioners and physician assistants today continue to be quality of care, perceptions by patients, physician acceptance (including delegation of tasks), productivity, state restrictions, and reimbursement for services.

Patient acceptance high

For services they are trained to provide, NPs and PAs deliver care of a quality equal to that of a physician. In this, all studies concur, within the constraints of present methods of measuring quality of health and medical care. Patients' perceptions of care they receive, usually measured by satisfaction, have shown complete acceptance of NP/PAs as providers of care.

Today the majority of nurse practitioners and physician assistants are in primary care.

But physician acceptance is equivocal. Most physicians who have worked with NP/PAs support their utilization, but these represent a small proportion of physicians. In 1980, there are an estimated 20,000 NP/PAs compared with 167,000 primary care physicians. Studies of physician demand for these providers document many reasons why physicians do not incorporate them into their practices. The principal reason given is that the practice does not need an additional provider, but a distaste for supervising and fear of malpractice suits are also factors.

With regard to number of patients seen in a specified time period, it appears that NP/PAs are less productive than physicians. From 1½ to 2 NP/PAs are required to provide the number of services that could be provided by a physician, it is estimated. PAs are more productive than NPs in performing medical tasks but it must be remembered that NPs often perform nursing tasks as well.

Do these differences in productivity result from differences among the providers themselves or differences in the kinds of patients and problems they manage? Unfortunately, this cannot be determined from available data.

States often limit use

There are two fundamental constraints on the ability of nurse practitioners and physician assistants to increase access to primary care services:

- *State restrictions* under various professional practice acts, including requirements for supervision and restriction of activities permitted, including prescribing of drugs, and

- *Limitations on reimbursement* by third-party insurers, including Medicare and Medicaid, for the services of NP/PAs.

Some states require direct supervision (physician on the premises) of nurse practitioners, but the maximum number the physician may supervise is rarely specified. In 1978, nine states set a limit of one PA per physician, while 23 states limited the number of PAs to two. Requirements for direct physician supervision or limitations on the number of PAs a physician can supervise can be particularly constraining in their provision of primary care services. In states that allow physician supervision to be indirect (telephone communications, chart review, periodic physician visits, etc.), such requirements do not seriously restrict the use of NPs and PAs.

In the majority of states, NP/PAs are prohibited from prescribing drugs. Even where state legislation permits these providers to prescribe, state pharmacy statutes to the contrary may take precedence. Prohibitions against prescribing drugs limit the extent to which NPs and PAs can provide primary care services, particularly in settings remote from the physician. Some state legislatures have authorized experimental programs to allow PAs and NPs to prescribe drugs. These programs include on-going monitoring and evaluation of the drugs prescribed.

Getting reimbursed: a problem

Traditionally, neither public nor private third-party payers have

reimbursed directly for medical services provided by NPs and PAs. This is a disincentive for employing NPs and PAs in ambulatory-care practices, with the negative effect likely to be greater in small practices than in large organizations. For example, Medicare reimburses for NP or PA services under Part A (hospital insurance) but not under Part B (supplemental medical insurance for ambulatory care.) In ambulatory care settings, with the physician on-site, appropriate NP or PA services can be billed under the physician's name.

But in settings where a full-time physician may not be present, such as remote areas, direct reimbursement is precluded. The *Rural Health Clinics Act* was passed in 1977 to ameliorate this problem. The Act (P.L. 95-210) addressed the lack of health care in certain rural areas. Taking into account that many isolated communities were unable to attract or retain physicians, and that residents of these areas had to rely on clinics that could not follow the traditional model of physician delivery of medical services, the Act provided for Medicare and Medicaid reimbursement for NP and PA services in certified clinics.

Traditionally, third-party payers have not reimbursed directly for NP/PA services.

To be certified, a clinic must demonstrate that it is located in an area designated by the U.S. Bureau of the Census as rural and by the Secretary of the Department of Health and Human Services (DHHS) as having a shortage of personal health services or primary medical care manpower. In addition, these clinics can be certified only if the state does not explicitly prohibit the delivery of health care by an NP or PA and if the mode of health care delivery (e.g., physician-to-NP/PA ratio) conforms to state regulations. Clinics are reimbursed for NP and PA services on the basis of the "reasonable" costs to the clinic (including non-physician salaries, overhead, physician supervision, etc.).

As yet, however, only a relatively small number of clinics have been certified under the Act—498 as of June 1980. Of these, 107 have withdrawn. State restrictions may dilute the impact of the Act, even for those clinics where it might otherwise apply. Further, the example set by the *Rural Health Clinics Act* still has not increased the willingness of most private third-party payers to reimburse directly for NP and PA services.

(A discussion of rural health clinics and their implementation in one corner of the U.S.—New England—appeared in the August 1980 issue of *Forum.)*

Training, credentials vary

Especially in recent years, physician assistant training and work experience have tended toward uniformity. Earlier programs were designed to train PAs in various specific medical specialties, but since 1971 most PA training has aimed at producing assistants to primary care physicians. During the Vietnam War, individuals entering PA courses with prior training and experience as military medical corpsmen required only an abbreviated (one-year) program to become PAs. Since then, most trainees, lacking this background, undergo the full two-year PA course. This makes the program content more uniform. The national certifying examination, given by the National Academy of Physician Assistants and required before a PA may begin to practice, is also a unifying factor.

For nurse practitioners, however, there is no corollary examination. The only qualification for entry into practice as an NP is a license as a registered nurse. Although the American Nurses Association gives certifying examinations for different types of nurse practitioners (the equivalent of board examinations for physicians, indicating expert knowledge in a particular area), these are not required to practice.

The diversity of training programs for nurse practitioners and the range of services provided by graduates make a single qualifying examination impossible. Training ranges from a two-year master's level program in, say, nurse midwifery to a three-month certificate program in family planning for associate-degree graduates. Then there are pediatric, geriatric, and pyschiatric nurse practitioners with various levels of training. In 1979, 104 master's level and 133 certificate NP programs were offered nationwide (see Figures 1 and 2).

Figure 1.
Certificate Nurse Practitioner Programs, 1980

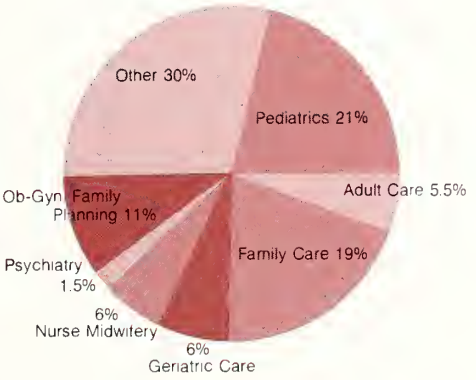
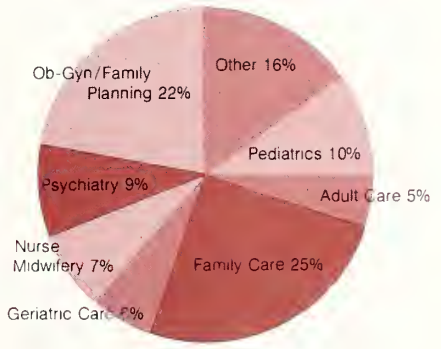


Figure 2.
Master's Level Nurse Practitioner Programs, 1980



Such disparities in training and credentials confuse both the public and the profession and make it difficult to assess the contribution of nurse practitioners in increasing access to primary care services.

Serving the underserved?

Have nurse practitioners and physician assistants located in communities in need of additional health services, thereby increasing access to primary care? The answer appears to be yes, but not to the extent envisioned by their proponents.

In 1977, about one-third of NPs and PAs were located in areas designated by the Federal Government to be in need of added medical services.

Both NPs and PAs are more likely than physicians to practice in communities of less than 10,000, according to data collected by NCHSR. On the other hand, the majority are employed in communities exceeding 50,000. This may reflect such constraints on employment, as the need for physician supervision and lack of third-party reimbursement. Distribution of PAs and NPs by size of community is compared to the distribution of physicians in Figure 3.

It is expected that the number of NPs and PAs trained for primary care will continue to increase in the 1980s, possibly doubling by the end of the decade. But there are strong suggestions that physicians may resist this trend and that NP/PAs will face increased competition for primary practice sites in less urbanized areas.

Federal support for increasing primary care services has concentrated on physicians. It is too early to ascertain the effect of the *Health Professions Educational Assistance Act* of 1976 (P.L. 94-484), which focuses on increasing family practice programs for MDs. However, preliminary evidence suggests that, as this supply increases, the graduates are locating in less urban areas. Primary practice settings that previously utilized only NPs and PAs are being usurped by physicians.

Other uses foreseen

There is no doubt that NPs and PAs can provide services to patients in need of care. But how they will be employed in the future, in the face of a growing supply of primary care physicians, is a matter of policy debate.

Care of the aging and chronically ill in secondary and tertiary care facilities seems an obvious alternative field for NP/PAs. The needs of these populations for primary, secondary, and tertiary care are great, and the likelihood of physicians providing such care is small. The quality of services in long-term care facilities and home-care programs could be upgraded through increased use of NPs and PAs. (Although, to be financially feasible, problems relating to third-party reimbursement for such care must be resolved.)

Another factor tending to support increased use of NPs and PAs in the provision of long-term care for institutionalized patients is the cutback in the number of foreign medical graduates entering the country. This results from restrictions set forth in the *Human Professions Educational Assistance Act*. Foreign graduates represent one-fifth of all physicians in the United States and close to one-third of all hospital-based physicians, predominating in state mental hospitals and hospitals without university affilitation. Constriction of the number of such graduates presents many institutions with medical manpower problems, to which recruitment of NPs and PAs might offer a least partial solution.

Already there has been a growing emphasis on training of geriatric nurse practitioners, and a few programs are preparing PAs to replace residents in hospital surgery staffs—to assist in the operating room, manage pre- and post-operative care, and do work-ups of newly admitted patients.

A major refocus of the training and utilization of physician assistants and nurse practitioners should be to combine primary care with a program of comprehensive services to the chronically or mentally ill and the disabled elderly. Such patients require a long-term commitment from the provider. Future recruitment should be directed toward students willing to assume this commitment in the role of a physician assistant or nurse practitioner.

The efficacy and feasibility of services by NPs and PAs have been demonstrated. Problems relating to state restrictions on their utilization and reimbursement for their services must be resolved. But beyond these, it remains only to channel the preparation and use of these valuable providers of care to meet the needs of the 80s and beyond . . . the needs of our aged and chronically ill citizens.

Figure 3. Distribution of Physicians, Nurse Practitioners, and Physician Assistants by Community Size, 1977-1979

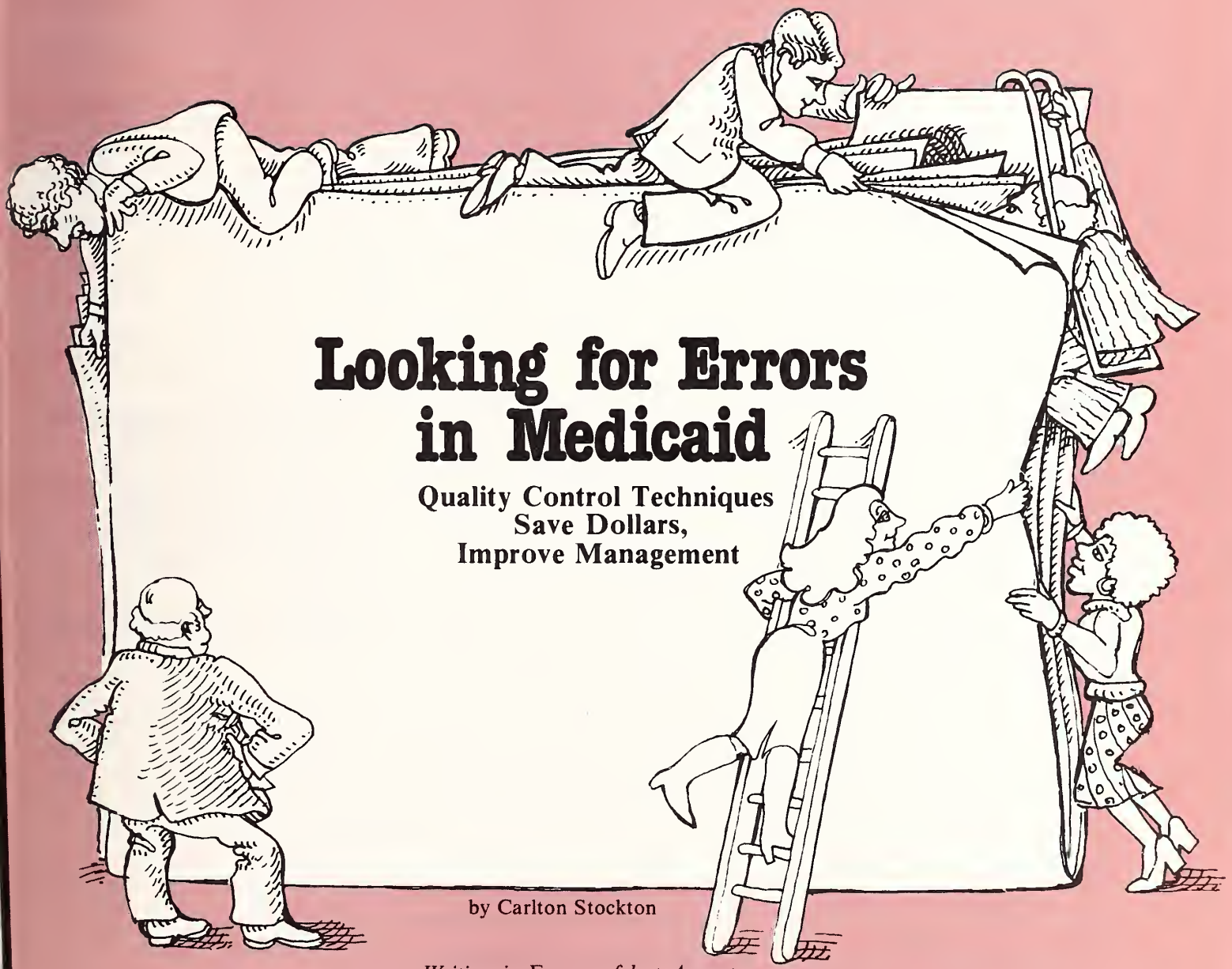
	Active Nonfederal Physicians*		Population-to-Ratio Physician	Nurse Practioners**		Physician Assistants***	
Community Size	Total	%		Total	%	Total	%
U.S. Total	377,047	100.0%	578	7,154	100.0%	7,577	100.0%
Over 500,000	261,571	69.4	452	2,970	41.5	2,541	33.5
50,000—500,000	91,176	24.2	698	2,808	39.2	3,001	39.6
25,000—50,000	13,936	3.7	1,210	468	6.5	650	8.6
10,000—25,000	8,422	2.2	1,763	312	4.4	549	7.3
Less than 10,000	1,942	.5	2,260	596	8.4	836	11.0

Sources:

*American Medical Association, 1978. Excludes physicians in U.S. possessions without community designations

**National Center for Health Services Research, 1977. Based on last known address of graduates of practitioner programs. An update is in progress, as there have been approximately 6,000 additional graduates since these data were collected

***American Association of Physician Assistants, 1979. All certified physician assistants



Looking for Errors in Medicaid

Quality Control Techniques Save Dollars, Improve Management

by Carlton Stockton

Writing in Forum *of last August, Don Nicholson discussed "program validation," a HCFA program that helps control dollar waste in Medicare and Medicaid by uncovering cases of aberrant costs, abuse or fraud in ambulatory care, and inappropriate reimbursement. In this article, Carlton Stockton describes a different HCFA approach to controlling Medicaid expenditures--quality control. QC employs systematic sampling to produce data on eligibility determination, claims processing, and third-party reimbursement in order to locate errors and make corrections.*

SINCE THE INCEPTION OF the Medicaid program, public managers and policy experts have attempted to find ways to curb the rising cost of health care services by reducing erroneous payment. Economic forecasts for at least the next five years indicate health expenditures, especially hospital costs, continuing to rise; ongoing high rates of unemployment; and no significant reduction in the overall rate of inflation.

If, in the face of this gloomy economic outlook, needy persons are to continue to have access to medical care promised by Medicaid, the program must have safeguards to assure that only eligible persons are covered and that errors in determining such eligibility and in paying claims for services are eliminated or sharply reduced.

The Health Care Financing Administration, which administers Medicaid on the federal level, and the state Medicaid programs have coordinated in establishing systems aimed at these goals. The success of their efforts is reflected in a report* on Medicaid error rates recently released by Secretary of Health and Human Services, Patricia Roberts Harris.

Overall, state Medicaid agencies reduced errors in the amount of payments to ineligible recipients from 6.2 percent in the six-month period ending December 1978 to 5 percent for the six-month period that ended September 1979, according to the report. The goal of each state was to cut its error rate for the latter period to the national average of 6.2 percent or to reduce errors by 15.7 percent, whichever reduction was smaller. Eleven states that had eligibility payment error rates above the national average for the July-December 1978 base period successfully achieved their error-reduction targets (see Figure 1).

Carlton Stockton is director of the Division of Quality Control Review, Bureau of Quality Control.

*HCFA, *Medicaid Quality Control Report for Periods April-September 1979 and July-September 1978* (HCFA-80-40003), September 1980.

However, 18 states failed to reduce their error rate to established national standards. If corrective measures are not implemented, they may be subject to a reduction in federal matching funds. Most errors in determining Medicaid eligibility concern the applicant's income or resources, the report indicated. Mistakes concerning income represent a large proportion of the *number* of errors, although not so great a proportion of dollars. In contrast, resources above the state limit account for 58 percent of dollars spent in error, which suggests that corrective measures in this area could dramatically reduce states' eligibility error rates.

Current data indicate that two-thirds of all eligibility errors are made by state agency staff, rather than by recipients, most often when the agency fails to take action on available information.

Identifying errors

The method by which program errors are being identified is the Medicaid quality control (MQC) system, set up by the Department of Health, Education, and Welfare (now HHS) and the states in 1975 and modified in 1978. It is designed to detect payment and other types of errors in the program and to produce an information base for implementing corrective measures.

Most errors in determining Medicaid eligibility concern applicant income or resources.

As in industrial quality control programs, Medicaid judges the overall quality of its "products" (cases) by inspecting a statistically valid sample. This technique is an economical and valid method for determining the quality of eligibility determination and claims payments.

A state-operated management system, MQC is designed to detect errors relating to eligibility, third-party recovery, and claims processing. Its goal is to assure that public funds are spent only on behalf of people who are eligible under federal and state laws, now some 25 million.

The system monitors a flow of $27.8 billion(in fiscal 1981) of federal and state funds for inpatient-outpatient services, physician care, laboratory and x-ray services, skilled nursing care, home health care, family planning, preventive health care for children, rural health clinic services, and optional services covered by states.

Approximately 1,000 employees in state Medicaid agencies are involved in implementation of MQC.

Medicaid judges the overall quality of its cases by inspecting a statistically valid sample.

MQC state staff review a sample of cases in the Medicaid population on a six-month cycle, from October to March and April to September each year. The sampling unit is a Medicaid case, which may be an individual or a family on the state's eligibility roles. Out of an estimated 9.3 million cases in the Medicaid program, states sample 78,000 cases semi-annually. The Federal Government then re-reviews 16,000 of these cases to assure the accuracy of state findings.

Looking for ineligibles

Because reimbursements on behalf of ineligible persons are the foremost cause of misspent Medicaid dollars, the MQC effort focuses first on this factor. (Applicants may approach one of three "doors" leading to eligibility for Medicaid: eligibility for the aid to families with dependent children (AFDC) program; eligibility for the supplemental security income (SSI) program for the elderly, blind, and disabled; or, in 32 states, qualification as medically needy under optional Medicaid rules.)

Figure 1. Avoiding Penalties by Cutting Error Rates*

States	Error Rates			
	July-Dec. 1978	Target	Apr.-Sep. 1979	Percent Decrease
California	7.5%	6.4%	3.4%	55%
Connecticut	10.2	8.6	6.0	41
District of Columbia	7.1	6.2	3.5	51
Georgia	9.1	7.6	6.9	24
Michigan	8.3	7.0	5.5	34
Minnesota	11.5	9.7	0.9	92
Mississippi	7.2	6.2	5.9	18
North Carolina	8.0	6.7	3.5	56
Ohio	11.6	9.8	6.5	44
South Dakota	11.6	9.8	3.6	69
Wisconsin	11.5	9.7	8.0	30

*States that are penalty-liable based on the July-December 1978 review, but reduced their error rates to avoid a disallowance.

First, state agency personnel select a systematic, random sample of cases in the Medicaid population from the state's master eligibility file. Reviewers examine the eligibility status of each case member to determine if all were eligible for Medicaid during the month of review.

Some states with small Medicaid case loads employ as few as one or two reviewers, while in larger states there may be as many as 100. Reviewers make home visits to verify eligibility, as well as contacting banks and employers of enrollees, when required.

Both the AFDC and SSI programs established quality control systems prior to Medicaid's. Since Medicaid accepts the eligibility determinations of AFDC and SSI to determine Medicaid eligibility, the MQC examiners use findings from the quality control systems of the other two programs to obtain information about their beneficiaries who are also covered by Medicaid. Through this integrated system, duplicative reviews are avoided, and sample accuracy is increased.

AFDC and SSI cases that are determined to be ineligible are re-reviewed by the MQC programs to determined if case members are eligible for Medicaid under other coverage provisions. After state MQC workers complete their reviews of ineligible cases, federal reviewers examine a sample to validate state findings.

"Spenddown" is a program feature that affects eligibility and is the source of many errors. This is the process by which an individual or family with income in excess of the state's standard can become eligible for Medicaid. To do so, the potential beneficiary applies such excess toward his or her medical expenses. Once the excess is "spent down" to the permissible level in this manner, the individual (or family) is eligible for Medicaid. Thirty-two state Medicaid programs allow spenddown of income.

MQC monitors a flow of $27.8 billion in Medicaid funds.

Medicaid policy on spenddown is complex, and there is no uniform application of policy in practice among all states. HCFA is exploring ways to better define and clarify spenddown.

Losing dollars through claims errors

Prior to the establishment of MQC, there was no systematic review of claims paid under Medicaid. Yet claims processing is another major area in which dollars are lost through error. While federal experience in reviewing claims processing by state programs is still limited, preliminary findings suggest that this may be an area where substantial improvements can be made in the operation of the entire Medicaid program.

Currently, some 35 states contract with fiscal agents (insurance or data processing firms as a rule) to process all or part of their Medicaid claims. However, in performing MQC reviews, HCFA staff turns to the state Medicaid agency, which is legally responsible for handling of federal funds.

MQC review of claims processing now works as follows. Five months after the month for which sample cases are selected, state reviewers collect all paid claims for services delivered to members of those cases. Claims are checked for:

- Services not authorized under the state's Medicaid plan;
- Uncertified providers;
- Duplicative services; *and*
- Reimbursement above the allowable level.

Federal MQC staff then re-check some of the claims, preferably examining the original bills from providers to avoid errors when claims

are transcribed to tape or computer printout.

Early reviews uncovered millions of dollars of paid claims stored in boxes in warehouses, without any system for filing or retrieving them. Many of the bills may have been paid after only a cursory review. MQC review in these states has been used to encourage the installation of a Medicaid management information system (MMIS).

An MMIS is a computerized system for claims processing and information retrieval that meets federal standards. At present, 33 states have an MMIS in operation.

Federal reviewers have found millions of dollars of paid claims in boxes in warehouses, with no system to file or retrieve them.

Federal legislation passed last fall mandates that all states participating in Medicaid develop an operational MMIS on a timely basis. States that do not do so face reduction in the federal payment they receive under Medicaid. The legislation also establishes claims processing performance standards that many states now lack and provides for a yearly federal review, with other penalties to ensure compliance. The goal, of course, is conservation of state and federal tax funds, while ensuring coverage of medical services to eligible needy persons.

As an example, in one state, the federal MQC claims processing review uncovered substantial Medicaid funds that were not being reviewed by the state, as well as a major flaw in the contractual relationship between the state and its fiscal agent. The state is renegotiating the terms of the contract to correct these problems.

Hunting the elusive payer

For a surprising number of Medicaid beneficiaries, there are other "third parties" that are liable for some

Paying for Medicaid

Health Care Financing Administration keeps track of some $16.6 billion a year in federal Medicaid funds. Of the total, $15.7 billion is the federal share of Medicaid payments to providers of services, plus $900 million for state administrative costs. (These figures are for Fiscal Year 1981.)

HCFA staff prepares quarterly and yearly Medicaid budgets, gets the necessary funds to the states, and tries to make sure the states spend them in accordance with the law and regulations.

Medicaid is the biggest single federal program of grants-in-aid to the states. An efficient financial operation helps determine how effectively the Medicaid program serves some 19 million recipients, how smoothly the money flows to the states, and how many taxpayer dollars are saved through fair and efficient operation.

The first step is getting the money from Congress. Because Medicaid is an "open-ended," matching, federal/state program, it is difficult to predict expenditures. The states administer the program, seeing that medical costs are reimbursed for all persons who need care and are eligible. Whatever a state spends on Medicaid, the Federal Government matches, according to formulas set in law and regulation.

(Nationwide, the federal match is 55 percent, on average. Poor states get a higher percentage than richer states, hence the Federal Government pays 78 percent of Mississippi's Medicaid bill, but only 50 percent for California and New York. For some services, such as family planning and design and development of an MMIS, the federal share is 90 percent.)

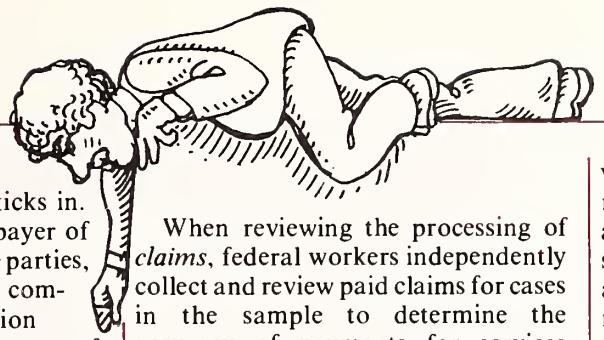
Budget analysts must predict total fiscal year costs from 21 to 27 months before the end of that year. If they estimate too high, other fixed-budget programs in HHS (which has an overall dollar ceiling imposed by Congress) will be allocated less, but there will be money left over at year's end the other programs cannot use. If the estimate is too low, HCFA must turn to the Congress for supplemental appropriations.

Budget accuracy depends on state estimates. Thus HCFA central and regional staff work closely with state Medicaid agencies, which prepare quarterly budget estimates. Complicating the task are differing state budget cycles and occasional changes in federal Medicaid rules.

Getting the states their Medicaid grants quarterly is a carefully orchestrated process. The states tell HCFA what federal funds they expect to need 45 days before the quarter begins and certify that they have the required matching money. After reviewing the requests for accuracy and allowability, HCFA develops estimates on which the grants are based and issues the grants to the states.

At the same time, the states report their Medicaid expenditures for the previous quarter. If the sum differs from the prior estimates, the dollars the state will receive for the coming quarter are adjusted accordingly. Then the money begins to flow—from the Department of the Treasury to the Secretary of Health and Human Services and ultimately to the states. Each quarter, HCFA officials sign off on an average of $4 billion in grants to the states (FY 1981 figures).

Are there sometimes mistakes? Of course. With 49 states, the District of Columbia, five other jurisdictions, and the Federal Government all helping to run the program, errors will creep in. Quality control—cutting program error rates—is the response.
response.



or even all medical bills incurred, before Medicaid kicks in. Under law, Medicaid is the payer of last resort— after other liable parties, such as Medicare, insurance companies, workers' compensation plans, absent fathers, and estates of deceased persons have paid their proper share of a beneficiary's medical expenses.

When determining eligibility, most states ask potential recipients whether they have health insurance coverage and check for other indications of third-party liability for medical costs. Information on third-party liability is gathered through face-to-face interviews with individuals determined eligible. Some states require that beneficiaries assign to the state any benefits from medical insurance (although this is not a condition of eligibility in all states). Recently, major improvements have been made in QC ability to detect errors relating to third-party liability and encourage corrective action.

Generally, federal-level reviews concerning eligibility, claims, and third-party liability are performed by HCFA personnel from the ten federal regional offices. At each office, there are from three to seven reviewers who monitor samples of Medicaid cases that were examined first by state Medicaid agency personnel.

Other "third parties" are liable for some medical bills incurred by Medicaid beneficiaries.

In reviews for *eligibility* and *third-party liability*, regional personnel conduct a desk audit, examining the state MQC file and the agency case record for the beneficiary to determine if the records show the elements required for eligibility and if state reviewers properly applied MQC procedures. The federal reviewers look for inconsistencies or inaccuracies, resolve these if possible, and make a determination. They may contact the beneficiary or other sources to fill in gaps in information.

When reviewing the processing of *claims*, federal workers independently collect and review paid claims for cases in the sample to determine the accuracy of payments for services during the review month and to check for third-party resources.

Taking corrective action

MQC is of little more than academic interest unless it results in corrective action—unless program managers use the data generated to make systematic changes that will prevent the recurrence of errors detected during reviews. Secretary Harris, in announcing the latest MQC findings, made the emphasis on corrective action clear. She said:

"I am asking the states which seek a waiver of sanctions under the Department's regulations to submit to me as soon as possible clear evidence of good cause and a corrective action plan which would eliminate payment errors. Assessment of existence of good cause permitting a waiver will be made on a case-by-case basis. Those states which do not show good cause will have sanctions applied, but if the states have provided an acceptable plan for elimination of errors, there will be a suspension of the disallowance funds."

By regulation, all states participating in the nation-wide Medicaid program (only Arizona is not part of it) must submit a formal plan each July that specifies what actions are planned to correct problems uncovered through MQC. In practice, of course, most states initiate corrective action throughout the year, based on individual case findings or on a pattern of findings that points to system defects.

Both state and federal MQC staff play a significant role in planning corrective action, because of their familiarity with review findings and with state and federal Medicaid policy (before reaching definitive conclusions on errors, reviewers must verify their decisions against applicable rules and regulations).

Some states and several federal regional offices have formed corrective action committees as vehicles to bring together top welfare managers to decide among alternative approaches to QC problems. Federal staff also provide on-site technical assistance to states that request help in reducing high error rates.

Lessons learned from MQC

One aspect of MQC is regulatory: states that fail to reduce payment error rates to national standards may face reduction in federal matching funds. In the past, threat of such penalty may have distracted data users from the advantages of the system. MQC data can be a valuable and powerful tool to pinpoint imperfections in complex Medicaid policies and procedures at both federal and state levels and a catalyst to initiating corrective measures.

Quality control is of little more than academic interest unless corrective action results.

Data from quality control reviews led one state to increase its third-party liability recovery staff and correspondingly increase its collections from liable third parties from $800,000 in fiscal 1978 to $6.7 million in fiscal 1980. Also as a result of MQC findings, many state Medicaid agencies have established working relationships with major insurance carriers to explore the feasibility of comparing data on beneficiaries.

Medicaid quality control has frequently brought state and federal Medicaid managers together to resolve complex policy issues. For instance, discrepancies are often found between a state Medicaid plan (each state must develop and have approved by HHS a plan detailing its Medicaid program) and the manuals and procedures actually in use. MQC reviews have focused state attention on obsolete data policies and conflicting procedures. Also, federal procedures for reviewing and approving changes to state plans are being reevaluated as a result of MQC findings.

HCFA has implemented self-monitoring to ensure uniformity and correctness in the interpretation and application of quality control procedures nationally. At least once a year, a team of central office and regional QC staff assesses regional and some state operations, reviewing case files and evaluating decisions reached on individual cases. To keep in touch with regional staff on QC matters, monthly telephone conferences and quarterly meetings are held, with follow-up visits made to selected regions. These procedures also serve as a vehicle for modifying the program and a basis for developing needed QC procedures.

MQC for the 80s

In this decade, federal and state budgets for medical services to the poor face several constraints, and some states are electing to decrease their benefit packages. MQC efforts can prove valuable in assuring that available services reach appropriate beneficiaries.

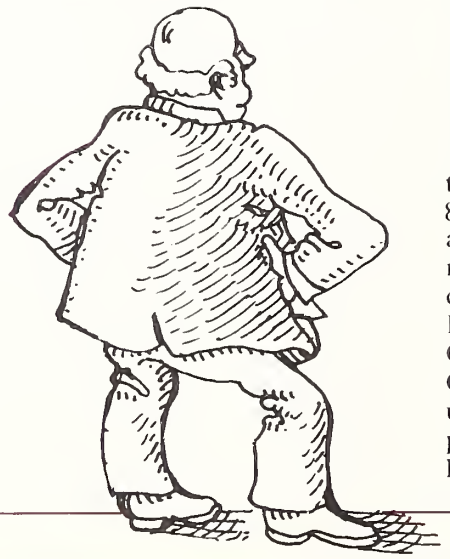
Quality control provides interpretative analysis for Medicaid managers.

Constrained resources and rising costs make programs such as Medicaid quality control, which conserves funds for eligible beneficiaries, a vital part of Medicaid management.

At the federal level, there will be increased attention to development of uniform quality control procedures across programs for the poor—food stamps, AFDC, SSI, and Medicaid. Some efforts in developing common error codes and implementing common worksheets have already been initiated. Such measures can reduce the cost of QC reviews across the country, while management information continues to be collected.

The process of review will also receive attention, with federal efforts to develop standards that clarify what is expected at each phase of review. This improvement, plus continued assessment by HCFA's central office staff of regional review activities, should go a long way towards uniform interpretation of MQC review instructions.

By 1982, MQC reviewers should be selecting claims for review in a different way, picking those that involve big dollars, rather than reviewing all claims connected with a specific case. Breaking the link between cases and claims will also do away with the delay now involved after a case is selected and before claims are examined, providing better data cheaper and quicker.



Handling and review of third-party liability should become more sophisticated, with more states establishing links with Blue Cross and Blue Shield plans to compare coverage of beneficiaries' medical costs.

The most significant contribution to the quality control effort during the 80s will be the capacity to provide analysis of error-causing factors for managers, as well as to facilitate corrective action, according to John Berry, director of HCFA's Office of Quality Control Programs. Through QC, the Medicaid program will uncover flaws in policy and procedures at the federal and state levels.

A · TALE · OF TWO TRUST FUNDS

By Guy King

WHILE MOST HEALTH CARE professionals who deal with Medicare know in general how it is financed, probably few are aware of the complexities of this subject or of the financial strains Medicare faces in coming years.

Medicare is actually two programs. One program, covering medical costs for enrollees, is financially sound, while the hospital insurance program faces fiscal trouble. The differences in financial outlook reflect the different ways the two kinds of coverage are funded, with hospital insurance more subject to the vagaries of the economy and inflation. Sound, long-term solutions to the problems are by no means apparent.

All financial operations of Medicare are handled through the two Medicare trust funds, the Federal Hospital Insurance (HI) Trust Fund (Part A of Medicare) and the Federal Supplementary Medical Insurance (SMI) Trust Fund (Part B of Medicare). Both funds, established on July 30, 1965, as separate accounts in the U.S. Treasury, are held by the Board of Trustees under the authority of the Social Security Act.

Three federal Departments are involved. The Secretaries of Treasury, Labor, and Health and Human Services comprise the board, with the head of Treasury designated by law as Managing Trustee. The Administrator of the Health Care Financing Administration serves as Secretary of the Board.

Each year the Board submits to the Congress an extensive report on the financial operations of each trust fund, detailing past financial operations and estimating future experience. The most recent such documents are the annual reports for 1980,* from which the projections in this article are drawn.

Payroll tax funds Part A

Contributions by workers and their employers (FICA taxes) and by self-employed individuals (SECA taxes) in work covered by the social security Old-age, Survivors, and Disability Insurance (OASDI) program make up the major receipts of the hospital insurance trust fund (see Figure 1 for receipts). Similar contributions are paid by and on behalf of employees of state and local governments that elect coverage under the program. The hospital insurance program also covers workers protected by railroad retirement.

In general, an individual's contributions are computed on annual wages or self-employment income, or both combined, up to a specified maximum annual amount commonly known as the social security wage base. Contributions are determined first on the wages and then on any self-employment income up to the annual maximum amount.

All contributions are collected by the Internal Revenue Service and deposited in the general fund of the Treasury as internal revenue collections (except for amounts received under state agreements and deposited directly in the trust fund and amounts collected by the Railroad Retirement Board that are later transferred into the trust fund).

Contributions received are immediately and automatically appropriated to the trust fund on an estimated basis, but the exact amount is not known initially. This is because hospital insurance contributions, OASDI contributions, and individual income taxes are not separately identified in the collection reports received by the Treasury Department.

Guy King is chief actuary for the Health Care Financing Administration and directs its Office of Financial and Actuarial Analysis, under the Office of Research, Demonstrations, and Statistics. Mr. King has submitted an article critiquing the economic assumptions of the 1980 Medicare trustees' reports to the Transactions *of the Society of Actuaries. It is scheduled to appear in 1981.*

**1980 Annual Report, Federal Supplementary Medical Insurance Trust Fund,* House Document No. 96-334, and *1980 Annual Report, Federal Hospital Insurance Trust Fund,* House Document No. 96-333. Both issued by the 96th Congress, 2d Session.

To the extent that estimates differ from contributions actually payable on the basis of reported earnings, periodic adjustments are subsequently made to the fund.

An employee who worked for more than one employer during a year and paid contributions on wages in excess of the statutory maximum may receive a refund of the contributions he paid on such excess wages. The amount of contributions subject to refund for any period is a charge against the trust fund.

Excess funds invested

Interest on investments held by the fund forms another source of income of the trust fund. That portion of the trust fund not required to meet current expenditures for benefits and administration is invested in any of three ways:

- Interest-bearing obligations of the U.S. Government;
- Obligations guaranteed as to both principal and interest by the United States, or
- Certain federally sponsored agency obligations designated in the laws authorizing their issuance as lawful investments for federally controlled fiduciary and trust funds.

These obligations may be acquired on original issue at the issue price or by purchase of outstanding obligations at their market price. The Act also authorizes the issuance of special public-debt obligations for purchase exclusively by the trust fund. By law, such special public-debt obligations must bear interest at a rate based on the average market yield on all marketable, interest-bearing obligations of the United States not due or callable for more than four years.

Paying for hospital care

The primary expenditures made by the HI trust fund are, of course, to cover costs of hospitalization and related care for Medicare enrollees (see Figure 1). Providers of care—hospitals, skilled nursing facilities, and home health agencies—receive interim payments for covered services for intermediaries (usually Blue Cross plans or insurance carriers). The provider bills the intermediary for an interim payment, either based on the days of care provided or for a previously negotiated bi-monthly sum. Either way, accounts are adjusted once a year when the provider submits an actual cost report to the intermediary. (Final reimbursement must be based on reasonable cost.)

Providers of hospital care are paid through intermediaries.

Intermediaries in turn collect reimbursement for their hospital insurance outlays from the Treasury under the "checks-paid" method. This means they draw against a bank's letter of credit from the HI trust fund. Payments to intermediaries are certified by the Secretary of Health and Human Services to the Managing Trustee, who makes the disbursement from the trust fund.

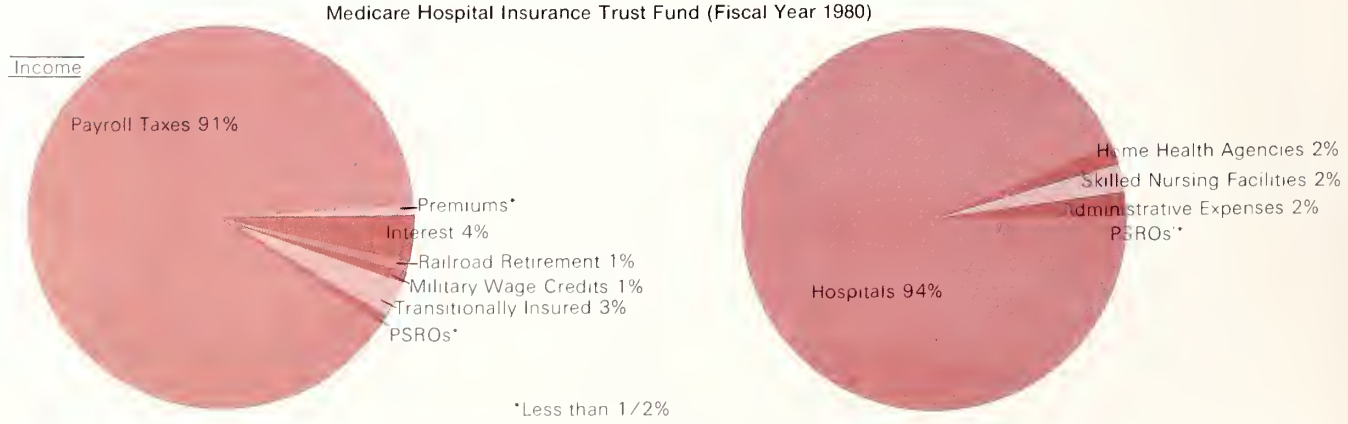
At their option, hospitals may combine billings for both hospital and physician components of radiology and pathology services provided hospital inpatients by hosiptal-based physicians. In such cases, the HI trust fund makes the initial payment, and is later reimbursed by the SMI trust fund.

Under certain circumstances, the HI trust fund pays hospitalization costs for persons not actually insured by Medicare. For instance, when the Medicare program began, certain uninsured persons were given coverage on a transitional basis. Payments on their behalf are made initially by the HI trust fund, but later reimbursed from the general fund of the Treasury. Other persons neither insured nor transitionally insured may enroll in Medicare and pay a monthly premium for hospital coverage; their care is financed by the trust fund.

Other trust fund expenditures and income relate to railroad retirees and Medicare enrollees with military service. The Railroad Retirement Act provides for a system of coordination and financial interchange between the railroad retirement and hospital insurance programs. Some 800 thousand railroad workers covered under the Act are eligible for hospital insurance coverage. In practice, this involves transfers of money into the HI trust fund from the Railroad Retirement Trust Fund.

For HI enrollees who saw military service, the Treasury general fund

Figure 1.
Medicare Hospital Insurance Trust Fund (Fiscal Year 1980)



*Less than 1/2%

annually reimburses the HI trust fund for costs arising from the granting of noncontributory wage credits. The Secretary of Health and Human Services periodically submits a determination of such costs.

The HI trust fund also pays for the reviews by Professional Standards Review Organizations (PSROs) of all hospital admissions under federal health insurance programs (required by the Social Security Amendments of 1972). Initially, payment is made by the trust fund; the general fund of the Treasury making reimbursement for review of non-Medicare admissions.

All administrative costs of Medicare Part A incurred by the Departments of Health and Human Services and Treasury are paid out of the HI trust fund. These expenditures are authorized by the Social Security Act and the Internal Revenue Code (the latter relates to the collection of contributions).

Finally, a broad range of experiments and demonstration projects, designed to determine ways to increase efficiency and economy in the provision of health care services under Medicare, is supported in good part from the HI trust fund. Payment for these projects, which HCFA conducts or oversees, is authorized by the Social Security Amendments of 1967 and 1972.

Part B covers aged, disabled

For the supplementary medical insurance trust fund (for Part B of Medicare), the major sources of income are premiums paid by eligible persons who voluntarily enroll in the program and contributions by the Federal Government through funds appropriated from general revenues (see Figure 2 for breakdown of income).

The Federal Government makes up the difference between enrollee payments and total costs of medical insurance.

Two broad categories of people are eligible for Part B: the aged and the disabled. Aged eligibles are persons aged 65 and over who are residents and citizens of the United States (or aliens lawfully admitted for permanent residence and with five years of continuous residence). Aged eligibles need not be covered by social security and, therefore, need not be entitled to hospital insurance. Disabled eligibles are persons under age 65 who have been entitled to social security disability benefits for the 24 preceding months, or who have end-stage renal disease requiring transplants or dialysis and meet certain additional social security coverage requirements.

Three rates determine the financing of the supplementary medical insurance program:

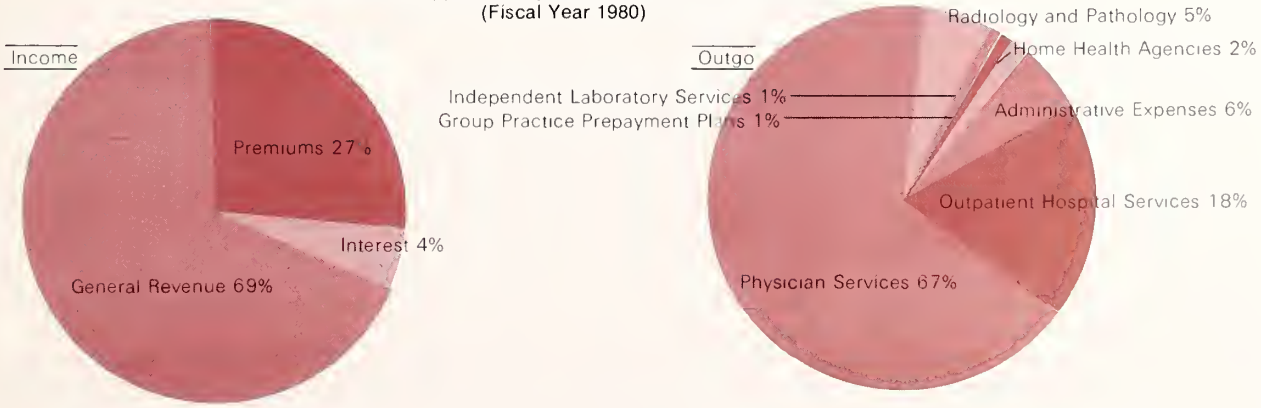
- Standard monthly premium rate that enrollees pay;
- Aged adequate actuarial rate; *and*
- Disabled adequate actuarial rate.

The aged adequate actuarial rate is one-half of the monthly incurred cost of benefits and administrative expenses for each aged enrollee, adjusted to allow for interest earnings on assets in the trust fund, contingency margin, and amortization of unfunded liabilities. For disabled enrollees, the adequate actuarial rate is determined similarly.

The standard monthly premium rate is now the same for both aged and disabled enrollees. Before July 1975, the premium rate was the aged adequate actuarial rate, but from then on, the premium was defined to be the lower of the aged adequate actuarial rate or the prior year's premium rate increased by the increase in benefits under OASDI. Each year, the Secretary of Health and Human Services announces the standard monthly premium and adequate actuarial rates, both determined on a July-June basis.

Federal matching contributions, appropriated from the general fund of the Treasury, are determined by applying a ratio, prescribed in the law for each group of participants, to the amount of premiums received from that group of participants. The ratio is equal to (1) twice the amount of the adequate actuarial rate applicable to the particular group of participants, minus the amount of the standard premium rate, divided by (2) the amount of the standard monthly

Figure 2.
Medicare Supplementary Medical Insurance Trust Fund
(Fiscal Year 1980)



premium rate. In essence, the ratio guarantees that the Federal Government will make up the difference between the total financing necessary for the program and the portion paid by the enrollees.

Interest received on investments held by the fund forms another source of income to the trust fund. The investments are handled similarly to those of the HI trust fund.

Disabled use more health care services per capita than do the aged.

The SMI trust fund pays for physician, radiology, pathology, outpatient hospital, home health, group practice, and independent laboratory services (see Figure 2 for breakdown). Payment is made through carriers (similar to intermediaries under the hospital insurance program). The method of payment is also similar to that for Part A, except that most services are billed and reimbursed on a reasonable-charge basis, thus eliminating the need for the final settlement process.

Expenditures from the SMI trust fund, in addition to benefit payments, include costs of administering the program and of conducting experiments and demonstration projects concerning reimbursements, waivers, coverage provisions, and the like. Procedures for determining benefit payments and allocating administrative expenses are similar to those of the HI trust fund.

Programs face different problems

Since the HI and SMI programs are financed differently, they are subject to different financial problems. The most recent information on the financial status of the two programs comes from the 1980 reports of the Board of Trustees.

For the SMI program, which is financed similarly to group health insurance, the premiums paid by beneficiaries and the general revenue amounts necessary to finance the program are determined only about a year in advance. Thus, the SMI program will be adequately financed as long as the projections of future program costs of the program are reasonably accurate. Monthly premiums to be paid by enrollees are projected to be $9.60 for the period July 1980 through June 1981, and the adequate actuarial rates that determine general revenue payments to the program are projected to be $16.30 for the aged and $25.50 for the disabled (experience has shown that of the two groups, the disabled utilize considerably more health care services per capita).

Under law, the SMI program must be financed on an accrual basis with a contingency margin. In practice, this means that the SMI trust fund balance should always be somewhat greater than the sum of claims that have been incurred by enrollees but not yet paid by the program. The assets and liabilities of the program as projected in the 1980 trustees' report are shown in Figure 3.

Thus, the SMI trust fund is financially sound through the end of the period for which financing was established—June 30, 1981—the 1980 trustees' report concluded.

HI fund: a cushion

As explained earlier, the HI program is financed primarily through its share of FICA and SECA taxes. Not "funded" in the same sense as a private insurance or pension plan, the HI trust fund serves only as a contingency reserve, providing a cushion for future fluctuations in the income and expenditures of the HI program. The HI trustees have established that the level of this reserve should be about 100 percent of projected disbursements for the following year.

But at the end of 1979, the hospital insurance trust fund held about $13.2 billion in assets, or only about 53 percent of the approximately $24.8 billion in disbursements for 1980. Thus, the trustees included the amount necessary to build the trust fund to the 100 percent level in their projected program costs.

The financial status of the HI program is expressed in what is called the "actuarial balance"—the average difference between tax rates currently scheduled in law and projected program costs over a given period.

An "actuarial deficit" or negative balance for the hospital insurance program is projected for the coming 25-year period, according to figures presented in the trustees' report. The basis for this deficit, the average difference between HI tax rates currently scheduled by law and projected program costs, is shown in Figure 4.

Projected program costs, expressed as a percentage of the nation's estimated taxable payroll, are the rates necessary to support program costs. Payroll projections for the next 25 years are, of course, an important determinant of the program's future. HCFA uses, with minor adjustments, payroll projections consistent with those made by the Social Security Administration, based on U.S. census data. The number of persons of working age in the population, degree of participation in the work force, unemployment rates, and assumed increases in wages in covered employment are the variables in an estimate of the taxable payroll.

The HI tax rate, which is a portion of the total social security taxes that worker and employer pay, is set by law. Rates shown in the table were established in 1977 legislation.

A negative balance is projected for the next 25 years of the hospital insurance program.

Thus, to fully finance the cost of the hospital insurance program over the next 25 years, *nearly one full percentage point would have to be added to the HI tax rate—an increase of some 35 percent.* If this were done, the average tax rate would approximately equal the average program cost, and the program would be "in actuarial balance." If the average tax rate should exceed the projected average cost, then an "actuarial surplus" would exist.

Although the hospital insurance program is not in imminent danger of

being unable to pay benefits, it will not have the funds to continue under the present tax schedule, as program costs are projected to exceed scheduled taxes in most future years. Thus, the financing schedule is inadequate, the report concluded. Tax rates specified in law (including scheduled increases in 1981, 1985, 1986) are sufficient, along with interest earnings, to support program expenditures over the next ten years. By 1990, however, disbursements exceed income, and the trust fund would be completely exhausted by about 1994.

Figure 3. Assets and Liabilities of Supplementary Medical Insurance Program

$ Millions				
Year (as of June 30)	Assets	Liabilities	Assets Minus Liabilities	Ratio to Next Year's Outlay
1980	$4,719	$3,017	$1,702	14
1981	4,729	3,514	1,215	8

Figure 4. Actuarial Balance of the Hospital Insurance Program

Actuarial Balance of the Hospital Insurance Program			
Year	HI Tax Rate	Projected Program Costs	Taxes Minus Cost
1980	2.10%	2.21%	-0.11%
1985	2.70	2.74	-0.04
1990	2.90	3.45	-0.55
1995	2.90	4.23	-1.33
2000	2.90	4.95	-2.05
25-Year Average	2.81%	3.80%	-0.99%

Solutions: Illusory or real?

The trust fund for supplementary medical insurance is sound, financially and actuarially. But rapid increases in the cost of medical care and in the beneficiary population will place growing strains on the ability of the Federal Government to appropriate its share of the cost of the program. For the hospital insurance program, even more serious problems exist, since the present financing schedule is inadequate to finance the program even through the 1990's.

Proposals have recently been made to allow interfund borrowing among the OASI, DI, and HI trust funds. While enactment of such a proposal would help alleviate temporary cash-flow problems that might arise, it would not provide a permanent answer to the need for sound, long-term financing for the OASDI and Medicare programs.

While increasing social security tax rates would constitute a simple solution to the financial problems of the hospital insurance program, raising them above the increases already scheduled in the law probably would be highly objectionable to most taxpayers and their elected representatives. Moreover, as long as hospital insurance program costs increase more rapidly than the taxable payroll, tax rates would have to continue to increase indefinitely. For example, the cost of the HI program, about 2.2 percent of the taxable payroll in 1980, is projected to become almost 5 percent of taxable payroll by the year 2000, while the scheduled tax rate is only 2.9 percent in 2000.

(Indeed many actuaries and economists feel that the assumptions on which the 1980 trustees' report projections were made are, if anything, too optimistic. Assumptions regarding future wage increases, upon which HI program income is partly dependent, may be too high relative to the estimated rate of inflation, as reflected in the consumer price index. The CPI assumption affects projections of health care expenditures under both parts of Medicare.)

Using general revenues to help finance the cost of the hospital insurance program has been suggested. This is an illusory solution, however, since the funds taken from general revenues would then have to be made up, either by increasing corporate or individual income taxes or by additional deficit spending.

Increasing the income tax, with its progressive rates (lower income people are taxed relatively less) is thought by some to be more equitable than raising social security taxes, which are levied at a flat rate. However, neither raising taxes nor increasing the federal deficit would probably be considered prudent or politically feasible in the current economic environment. Nor would most people feel it feasible to cut Medicare benefits to save money.

What, then can be done to improve the financial soundness of the Medicare program? The fundamental cause of its problems is that health care costs are increasing faster than the tax base. The obvious, though not easily achieved, solution lies in slowing the increase in the cost of health care to the minimum level consistent with sound medical practice.

As one of the major purchasers of health care, the Health Care Financing Administration has with some success encouraged cost consciousness on the part of health care providers by reducing reimbursement for costs or charges in excess of certain limits. However, reducing the rate of increase in health care costs significantly in the future will require increased cooperation among HCFA and others engaged in financing health care, on one hand, and those who provide health care, as well as patients and beneficiaries, on the other.

Thus, the burden of keeping the Medicare trust funds sound rests not only on the government, but on the health care professionals who participate in the Medicare program. ■

PUTTING HOSPITAL STANDARDS ON THE EXAMINING TABLE

JCAH Zeroes in on Quality of Care

by Howard Wolinsky

As the Joint Commission on Accreditation of Hospitals (JCAH) enters its 30th year of operation, it faces new challenges, both internal and external.

By establishing optimal standards for hospitals and other health care facilities, conducting on-site surveys, and awarding accreditation when warranted, JCAH works to promote high quality health care throughout the nation. But the way it does this has caused the private, non-profit organization to be publicly criticized as being inflexible and punitive in dealing with hospitals.

Criticism comes primarily from two major groups concerned with health-care, the American Medical Association (AMA) and the American Hospital Association (AHA), which are among the parent groups of this voluntary hospital-accrediting organization. (The other member organizations are the American College of Physicians, the American College of Surgeons, and the American Dental Association.)

JCAH has been criticized as being inflexible and punitive in dealing with hospitals.

Yet last year, the U.S. General Accounting Office (GAO) praised JCAH's efforts and recommended that JCAH determine the eligibility of *all* hospitals for participation in the federal Medicare program. Although JCAH officials were pleased by GAO's accolades, they also viewed its recommendations as a threat to the organization's voluntary aspect, the cornerstone of the JCAH philosophy.

In any case, JCAH is undergoing a major reorganization of its programs, begun before the current barrage of brickbats and bouquets started.

Roots of the dilemma

To understand JCAH's current dilemma, the organization's history must be examined. JCAH traces its roots to the Third Clinical Congress of Surgeons of North America in 1912, at which a resolution was adopted calling for development of "some system of standardization of hospital equipment and hospital work" to recognize the top hospitals and to encourage others to raise their standards.

"In this way patients will receive the best type of treatment, and the public will have some means of recognizing those institutions devoted to the highest ideals of medicine," the resolution concluded.

At this time, deplorable conditions existed in many American hospitals. Medical staffs generally were not organized and hospitals lacked clinical laboratories, x-ray, and other essential services for performing proper studies of surgical patients.

Nor were medical records satisfactory. The American College of Surgeons (formed in 1913 as a result of the meeting of surgeons the previous year) had to reject more

Howard Wolinsky is a professional writer with ten years' experience in the medical field. The recipient of national awards for health writing, he holds a BS in communications and an MS in journalism from the University of Illinois. He was a journalist-in-residence at the University of Michigan, focusing on health-related issues, under the National Endowment for the Humanities fellowship program.

than 60 percent of otherwise qualified candidates for fellows, because their hospital records were inadequate to demonstrate their abilities.

Recognizing the need to establish proper hospital standards, the ACS took as its mission the monitoring and upgrading of hospital standards. In 1917, ACS published a one-page set of minimum standards and the following year the voluntary "hospital standardization program." It offered accreditation to hospitals meeting standards concerning staff oranization, qualifications for staff membership, peer review, clinical record keeping, and diagnostic and therapeutic facilities.

As a result of these efforts, the quality of care in participating hospitals improved. A growing number of hospitals chose to undergo voluntary accreditation. The number of accredited hospitals grew from 89 in 1918 to more than 3,000 in 1951, more than half of hospitals in the country.

With increasing program costs, the explosion of medical knowledge and equipment, and the emergence of nonsurgical specialties after World War II, ACS saw the need for an independent accrediting body that involved other health-care groups.

Hospital officials and physicians started viewing JCAH as they would a regulatory government body.

The resulting organization was JCAH, which was founded in 1951 by the ACS, the American College of Physicians, AHA, AMA and the Canadian Medical Association. (In 1959, the Canadians left to form their own group.)

During the 1950s and 1960s, JCAH underwent a major expansion, writing standards in many new areas, such as nursing services and food preparation, and creating new accreditation programs. In 1980, the American Dental Association joined JCAH as a sponsor. Under JCAH today, 5,000 of 7,000 American hospitals are accredited.

The Chicago-based JCAH is governed by a 21-member board of commissioners, with seven commissioners each from AMA and AHA, three each from the ACS and the College of Physicians, and one from the dental group. The Commission operates on an $18 million budget, has 420 employees, including 185 field surveyors.

Criticism leveled at JCAH

But growth created problems for the JCAH, which in addition to its hospital program now accredits 1,200 psychiatric facilities, 1,100 long-term care facilities, and 125 ambulatory care organizations.

Hospitals began to criticize the accreditation process. Complaints peaked in the summer of 1980 at the annual meetings of the AMA and AHA. The groups argued that JCAH was inflexible and inconsistent in its interpretation of standards; that it was punitive in its dealings with facilities; and that its standards were confusing and added to costs at a time when hospitals were striving to contain costs.

Hospitals have, said AHA Chairman Sister Irene Kraus, "a growing concern about the ability of AHA commissioners [who serve on the JCAH board] to have impact on JCAH management and . . . decisions." The AMA's Texas delegation complained of "unnecessary and repetitious paperwork" resulting from JCAH requirements, while the AMA Arkansas delegation called a JCAH survey "more of an ordeal than a learning process."

Affeldt: "JCAH tries to find a consensus approach. But you'll always have critics."

Losing sight of the fact that accreditation was voluntary and that JCAH was a creature of their own creation, many hospital officials and physicians were viewing JCAH as they would a regulatory government body.

John Affeldt, MD, who became JCAH president in 1977 after serving five years as medical director of Los Angeles County Department of Health Services, acknowledges the criticisms are valid to a certain extent, but also thinks some are contradictory.

Affeldt: Some ambiguity necessary

"We hear complaints that standards need to be changed, that the critics would like them less ambiguous, more specific and shorter. Well, if you become more specific then your standards become lengthier rather than shorter," says Dr. Affeldt.

"There is a certain amount of ambiguity in the standards because we must apply them to the 50 states; to all types of hospitals, small, large, teaching, proprietary. Since we make no distinctions between hospitals we have to use such terms in the standards as reasonable and appropriate, terms the critics consider ambiguous. But if you start spelling it out, that the 50-bed hospital must have this, the 200-bed hospital must have that, you'll create greater problems than those caused by the current approach."

Criticism of JCAH is partially of a cyclical nature, Affeldt believes. Similar complaints arose in the AMA House of Delegates in the late 1950s. He also sees the complaints as a spill-over from the anti-regulatory mood in the country. Then too criticism may be built into JCAH.

"JCAH tries to find a consensus approach. It is obvious that, with multiple voices and multiple interests, you cannot please them all. You'll always have critics among those who are also your supporters," Affeldt says.

Duplication of effort on the part of JCAH has been a major topic of complaint by facilities, as well as between JCAH and governmental agencies. Hospitals would ask "Why do you come one month with this team, the next month with another team, to the same facility and survey some of the same things, such as the plant, the kitchen, and the administration? Why can't you get your act together?"

Dr. Affeldt was given the challenge of unifying JCAH's approach to accreditation through consolidation of JCAH programs.

Through its reorganization, says Affeldt, JCAH is consolidating what had been four separate programs: for acute hospitals and for long-term, psychiatric, and ambulatory facilities. The Commission's goal is to be able to send in one team of surveyors with a single set of standards into a facility that might have all four types of programs. He believes this unified approach will put to rest complaints that JCAH standards are expensive and confusing.

Avoiding duplication of effort

Also to help reduce duplication, JCAH increasingly is working with state licensing agencies to jointly survey health care facilities. These arrangements, which are in effect or are being discussed in 38 states, the District of Columbia and Puerto Rico, range from situations where the state agency and JCAH agree to visit the facility at the same time to states where JCAH accreditation is deemed adequate to qualify a facility for state licensure.

In New York State, for example, when a JCAH team comes in with a physician, registered nurse, hospital administrator, and (if needed) laboratory technician, a state inspector comes along to examine aspects where special state requirements apply.

During a survey, a JCAH team looks at about 6,000 different features of a hospital, noting about 2,000 of them in writing. A survey lasts from one to four days at a cost to the facility of from $1,800 to $2,400 per day. Based on the survey findings, the JCAH board's accreditation committee, whose members are practicing physicians and active hospital executives, determines the accreditation status of the facilities. When granted, accreditation may extend for one or two years.

California has gone the farthest of any state to avoid duplication of effort. There, by state law, a facility *must* apply to JCAH for accreditation. (The exception to this is a hospital that claims it cannot afford a survey or that claims JCAH would be biased against it; in such cases, the state inspects the facility.)

Thinking along the same lines as California, the GAO recommended in 1979 that JCAH certify *all* hospitals seeking to participate in Medicare. Hospitals currently meeting JCAH standards for accreditation are deemed to be in compliance with federal standards for Medicare eligibility, aside from requirements relating to utilization review and institutional planning. However, a hospital is not required to be JCAH-accredited to obtain Medicare reimbursement.

As JCAH's agreements vary from one state to another, JCAH has some concern that it could end up with 50 different arrangements, Affeldt said. This would make it more difficult to carry out an orderly process. Relationships such as that proposed by GAO and exemplified by California particularly worry JCAH.

"We do not wish to have our voluntary nature threatened—it is very important to the concept of JCAH. That is why we have not been willing to discuss contracting with HCFA to survey all hospitals," said Affeldt. "A government inspector must determine if the facility meets the minimum requirements, and this may be seen as having a punitive aspect.

In 1979, GAO recommended that JCAH certify **all** *hospitals seeking Medicare participation.*

"JCAH's voluntary approach is based on a very different philosophy. We have optimal achievable standards. Instead of saying, 'We've found a problem, and we're going to give you a black mark,' our surveyors would say, 'How can we help you improve?' We don't always achieve that, but that's our objective, what we train our surveyors to do."

In the near future, JCAH will complete major studies about future approaches to improve the accreditation process. It will explore whether there are better ways to conduct surveys, how a survey team's composition can be changed, and whether the length of accreditation should be expended to a maximum of three or even four years.

"Over the years, JCAH has attempted to change to meet the needs of changing health-care facilities," said Affeldt. "Our task is to continue the success of the voluntary approach to accreditation." ■

PUTTING HOSPITAL STANDARDS ON THE EXAMINING TABLE

HCFA and JCAH Cooperate in Monitoring Hospitals

by Margaret VanAmringe

The Joint Commission on Accreditation of Hospitals (JCAH) and the Department of Health and Human Services (DHHS) share a common goal—quality care for hospital patients—but they rely upon different incentives to achieve it.

JCAH expects that a desire for status and excellence will induce hospitals to meet the high standards specified in its accreditation program. DHHS, on the other hand, relies upon the hospital's need for federal funds as the incentive for compliance with the similar standards required for certification under the Medicare and Medicaid programs.

Is collaboration possible between two organizations, one private, the other public, that depend on such different motivations? Historically, the seemingly competitive, perhaps contradictory aspects of the accreditation and certification processes have resulted in a sometimes difficult relationship between JCAH and the Federal Government.

Yet, while legitimate differences exist, there are also mututal benefits to be achieved through interaction. This article describes how JCAH and HCFA have drawn closer together in recent years in their attitudes and the ways in which cooperative efforts have been carried out.

Under law, a "special relationship"

In the years prior to 1965, the Joint Commission on Accreditation of Hospitals was the nation's chief standard-setting organization for hospital medical care. With Congressional enactment of Medicare—a federally funded health insurance program for the aged—the federal investment in hospital care rose dramatically. Included within the 1965 amendment to the *Social Security Act* was the provision that the Department (then DHEW) certify that hospitals receiving federal funds meet certain health and safety standards. Although modeled after JCAH voluntary requirements, these conditions of participation signaled an end to private, health-provider dominated standards.

Later, the Medicaid amendments to the Act further expanded federal financing of medical care. (Now, almost 6,800 of the approximately 7,000 U.S. hospitals are certified to receive Medicare and Medicaid funds.)

JCAH and HCFA have drawn closer together in attitides and in willingness to cooperate with each other.

The 1965 amendment established a special relationship between Medicare and the JCAH accreditation program. An institution accredited as a hospital by the Commission was "deemed" to meet most of the certification requirements of Medicare, essentially giving it automatic eligibility in the Medicare program. (The exceptions were requirements for institutional planning by the hospital relating to capital expenditures and operating budgets, and review of the medical necessity, type, and duration of hospital services being utilized. For both, a federal survey was still required.)

Hospitals that did not choose to be accredited by JCAH were surveyed by the states, which were

Margaret VanAmringe is director of the division of hospital services in HCFA's Health Standards and Quality Bureau. She holds a BS from Albertus Magnus College in New Haven and an MPH from Johns Hopkins University School of Hygiene and Public Health, and has worked in health services research at two university hospitals.

empowered by the Department to apply the Medicare conditions of participation in these hospitals, and to make certification recommendations to the Secretary.

But, soon the special situation that existed between accredited hospitals and Medicare changed. Consumer groups challenged the right of the Department to unconditionally delegate to the Commission, a private organization, its statutory responsibility for protecting the health and safety of federal beneficiaries. In 1970, a class action suit on the matter was brought against both the Department and the Commission.

In 1972, JCAH accreditation was validated as proxy for compliance with Medicare standards.

During the years that consumer dissension was developing, difficulties unfolded directly between JCAH and the Department. By law, the Secretary was prohibited from promulgating any condition of participation that represented a standard higher than that of the Commission. Some states alleged that certain JCAH standards were less than adequate to protect the health and safety of patients, that the expertise of the JCAH teams was weak in several areas, and that the Commission did not adequately monitor deficiencies found in hospitals. The Commission viewed the federal conditions as absolute minimal standards for a hospital rather than optimal ones, and regarded the state surveyors who visited nonaccredited hospitals are lacking the experience of the JCAH survey team.

Eventually, Senate hearings were held on the JCAH process. The resulting provisions in the 1972 social security amendments authorized the Secretary to validate JCAH accreditation as a proxy for compliance with DHEW's conditions of participation. This appeased some consumer advocates (the class action suit mentioned above was dropped), but aggravated existing philosophical and political differences between the two organizations.

Validation surveys were to be performed by state survey agencies on a statistical sample basis or when there was a substantial allegation that the health and safety of patients in a particular hospital were jeopardized. If, during a validation survey, a hospital was found to be out of compliance with the federal conditions, that hospital would be subject to state surveillance. Another critical provision gave the Department authority to establish standards higher than those of the Commission.

Clash over disclosure

Through cooperative effort, the Commission, the American Hospital Association, and the Department established the procedures for conducting validation surveys of hospitals accredited by JCAH. The first surveys were performed in January 1974.

The subsequent *Report to Congress* on the initial ten months of experience produced a wave of controversy that made national headlines. Consumers focused on the finding that two-thirds of hospitals accredited by JCAH did not meet one or more requirements of the 1967 *Life Safety Code*. The report did recommend, however, that the Commission keep its deemed status.

Unfortunately, throughout the controversy, little attention was paid to the causes of disparate determinations between JCAH and state surveyors, which included use of different survey forms, varying training and experience of the surveyors, and the length of time a team spent examining a hospital. (JCAH and state survey findings differed in many areas, each organization finding some deficiencies missed by the other.) Nor was it widely noticed that the Commission was undertaking modifications to the accreditation program to improve the life safety portion.

By the end of 1975, the validation program had suffered a severe blow. Certain hospital-specific information that JCAH had released to the Department was redisclosed to a requester under the *Freedom of Information Act*. Claiming that such redisclosure was a violation of the law, JCAH formally protested by deferring further participation in the federal validation program until confidentiality could be assured and by filing suit against the Department. Validation surveys were temporarily suspended. Eventually they resumed, but without access to JCAH comparative information.

The Department soon modified its position on disclosure of JCAH information and reached an agreement that allowed validation surveys to resume in full force, but a toll had been paid. The Commission felt it had spent considerable resources since about 1970, dealing with the certification program, while the Department had devoted similar efforts and monies, even continuing validation surveys that had reduced value, due to the lack of JCAH data, to make comparability determinations.

In short, the functional relationship between the two programs was often strained during much of the decade of the 1970s.

Mutual appreciation replaces tensions

But today, tensions between the two organizations have essentially evaporated, replaced by better appreciation of each other's role in assuring good medical care and the problems encountered in so doing. To some extent, this improvement may have come about because of the dramatic rise in federal, state, and local regulations of hospital practices and the resulting economic pressures and frustrations from which the health care system is now suffering.

Aware of such pressures, the Department now recognizes the equivalency of JCAH and DHHS hospital standards by giving "deemed status" to the Commission for many additional conditions of participation whenever possible. This helps stretch the state and federal dollars available for survey activities, while maintaining standards.

For example, since 1978, deemed status has been granted for institutional planning and the revised JCAH hospital-based standards and has been proposed in regulation for utilization review. In addition, negotiations are nearing completion for deemed status in hospital-based, long-term-care and home-health facilities. Such an approach credits hospitals for their voluntary achievements and avoids duplicate surveys, while resulting in a substantial cost savings to both hospitals and government.

Increased sharing of information between HCFA and JCAH has improved accreditation and certification procedures.

Likewise, acknowledging the strain that public accountability has placed on hospitals, the JCAH has supported several projects to help hospitals eliminate unnecessary efforts in meeting JCAH and federal requirements. It has expended considerable resources encouraging states to coordinate their licensure surveys with certification and accreditation visits and promoting simultaneous surveys by JCAH and Professional Standards Review Organizations (PSROs).

(PSROs are physician-run organizations that review the appropriateness and quality of medical services provided under Medicare and Medicaid. Some PSRO requirements for quality assurance programs are similar to those placed on hospitals by JCAH accreditation standards.)

Last year, concurrent JCAH accreditation and DHHS validation surveys were conducted to discover whether joint surveys would be ultimately less disruptive and costly to a hospital than two separate visits. Now all accredited hospitals have the option of having these two surveys scheduled together.

Reorganizations bring new attitudes

But perhaps the most important determinant in the present spirit of cooperation between the Commission and DHHS has been their respective internal reorganizations, which brought changes in leadership and new attitudes toward partnership. Recently, accreditation power was centralized within JCAH, when its four distinct councils were abolished and merged with the hospital accreditation unit, resulting in a more efficient Commission with centrally determined, uniform accrediatation policies. Integrating all activities under a single leadership has facilitated DHHS's relationships with the Commission.

Reorganization on the federal side produced the Health Care Financing Administration (HCFA), which now administers the Medicare and Medicaid programs. Creation of HCFA was aimed at making the financing of health care more efficient, while assuring the quality of services paid for by the government. A HCFA action the Commission found helpful was the joining of certification and PSRO quality assurance activities under a new Health Standards and Quality Bureau. In

this unit was assembled a cadre of health professionals who understood the value of voluntary standards in achieving quality patient care.

Leadership in both organizations can now direct more attention to achievement of mutual objectives than to purported differences. Increased sharing of information and learning has improved accreditation and certification procedures. One example is a new validation process, proposed by the Department and supported both by the Commission and the states. Under it, only hospitals with "significant" deficiencies would be subject to removal of deemed status and surveillance by the state agency.

Avoiding survey duplication

Previously, if an accredited hospital was out of compliance with any condition of participation, state jurisdiction was automatically assumed, even if the deficiency did not threaten the health and safety of patients. Experience proved that this approach to validation resulted in many accredited hospitals being subjected to two types of surveys, state and JCAH, for correction of the same deficiencies. Not only was this duplicative and extremely costly to the health care system, but it reflected unfairly on the JCAH process of monitoring hospitals.

At the same time, there were allegations that some states unfairly increased the number of surveyors sent to validate an accredited hospital, a practice that was bound to result in states reporting higher numbers of deficiencies in accredited hospitals than in nonaccredited ones. (Prior to the Department's proposal to improve the validation process instructions went to states that they were to use a set number of surveyors for both certification and validation visits.)

Federal, state, and private accreditation efforts should not be duplicative, a re-examination of the Congressional intent behind the validation legislation indicates. Congress intended that DHHS should communicate and coordinate with the JCAH concerning a hospital's deficiencies before placing the institution under automatic state surveillance.

JCAH has been supportive of the Department's efforts to improve the validation process, even though some changes may require the Commission to use additional resources in reporting corrections to DHHS. Standardizing the number of surveyors allows a greater coordination of survey and accreditation activities, while achieving nationwide uniformity of criteria for placing a hospital under state agency surveillance.

Cooperating on fire safety

Setting of new standards is another area of mutual assistance between JCAH and HCFA, providing great potential for learning. Both organizations continually analyze and evaluate their own standards. Recently, the Department adopted a new fire safety evaluation system (FSES) that increases a hospital's flexibility in meeting federal fire safety standards without sacrificing protection. In addition to helping hospitals save money, the new system will result in a greater conformity between JCAH and state agency findings in life-safety areas.

There has been a good interchange on fire safety; the Commission has sent its surveyors to HCFA's training courses on the subject and has suggested that hospitals use FSES-trained state surveyors to evaluate life-safety capacity. Soon, JCAH will have strong FSES expertise as a result of a special training course it is instituting. In the area of hospital-based laboratory standards, the Department and the Commission worked together to implement new JCAH standards after the Department elevated its own laboratory standards.

Similarly, modifications in the JCAH quality assurance standards prompted the Department to re-evaluate its own requirements for medical care evaluation studies and to send staff to JCAH courses on their new standard. Coordination of the sometimes different PSRO and JCAH assurance activities is promoted through a task force that includes representatives from the Commission, the American Association of PSROs, the American Association of Medical Care Foundation, and HSQB/HCFA.

Excellence can be achieved through voluntary standards.

HSQB has recently completed a comparative analysis of JCAH standards and federal conditions of participation for hospitals. Many of the strong points of the JCAH standards should find their way into the new hospital requirements, when these become final as federal regulations in the summer of 1981. Through these and similar commitments to increase exchange of survey information, JCAH and DHHS have kept their new relationship active, while improving both sets of requirements.

Accreditation complements certification

The large number of hospitals that must be monitored makes reliance on accreditation necessary. But, the possibility of assuring improved quality of care is increased by a recognition that excellence can be achieved through voluntary standards. In fact, HSQB is proposing its own voluntary program for hospital laboratories to complement its existing standards.

At the same time, there is a new spirit at JCAH that attaches even greater importance to public accountability, openly supports the need for validation, and continues to inspire cooperation.

There seems to be a mutual understanding between JCAH and DHHS that the accreditation and certification systems are complementary, not competitive. To paraphrase the words of John Affeldt, MD, president of the Commission, agreement may not exist on every issue, but disagreement is no longer based on emotions or bias. The relationship between the two organizations has never been better.

Update

New payment method for kidney dialysis would promote savings

HCFA has proposed a new Medicare payment method for kidney dialysis designed to promote more efficient and economical dialysis services.

Under the method, Medicare would set national rates in advance, according to the type and location of the facility, then pay 80 percent of that rate. Facilities furnishing treatments more economically than the specified rate could keep the difference between their actual cost and the national rate. The rates would be adjusted periodically.

This method would apply to outpatient dialysis in a hospital or freestanding facility, and to programs that train patients to dialyze themselves at home.

Medicare, under Part B, now pays 80 percent of the average cost of outpatient treatment in a hospital and 80 percent of reasonable charges for independent facilities up to a limit of $138 per treatment, unless an exception is granted.

"Although our kidney program has been successful in protecting renal disease patients against the catastrophic costs of needed care, expenditures have skyrocketed from some $160 million in 1974 to about $850 million in 1979," said HCFA Administrator Howard Newman. "We feel that the method of reimbursement we propose would slow the increase in costs by promoting more efficient and cost-effective delivery of services through financial incentives."

The End-Stage Renal Disease Program, which began in 1973, provides Medicare coverage to the more than 45,000 people currently dependent on dialysis. It authorizes Medicare reimbursement for services in a hospital, including kidney transplants; for maintenance dialysis furnished on an outpatient basis in approved facilities or in the home; and it pays for training patients to dialyze themselves.

The proposed regulation allows for exceptions to the national rates: A higher reimbursement would be allowed for facilities that have an unusual patient case mix or other circumstances that make higher costs unavoidable. The regulation also provides a one-year transition period during the first year of implementation, allowing facilities with costs above the rate time to modify their operations, in order to furnish care more efficiently.

Facilities would be required to report their costs, as they do under current Medicare regulations. The reports would be used to monitor the program and to establish future rates.

Four national classifications of facilities are proposed: urban hospitals, urban independent facilities, rural hospitals and rural independent facilities. The rate for each facility would be composed of a portion covering salaries which would be adjusted by an area wage index and a portion covering other operating expenses.

The proposed regulation does not include the actual proposed rates. HCFA is conducting extensive audits on a statistically selected sample of facilities. Rates, to be included in the final regulation, will be based on the results of these audits.

Newman added that facilities should be able to achieve economies by shopping for the best prices in supplies and doing bulk buying when possible. He said the proposed regulation should also encourage improvement in administrative and management services and promote efficiencies in all types of operating costs.

Senator Schweiker named as HHS Secretary

Richard Schweiker, U.S. Senator from Pennsylvania, has been nominated by President-elect Ronald Reagon to be Secretary of Health and Human Services. Schweiker was ranking Republican member of the Senate Labor and Human Resources Committee and its health subcommittee. His appointment is subject to confirmation by the Senate.

Schweiker served in the House of Representatives from 1960 through 1968, when he was elected to the Senate. While in the Senate, he wrote bills to combat diabetes, cancer, heart disease, sickle cell anemia, and lead pain poisoning. A graduate of Pennsylvania State University, he was a business executive priior to 1960.

HCFA places cap on PSRO expenditures for hospital reviews

To help hold down costs of reviewing health care services by hospitals, the Health Care Financing Administration has issued regulations which would control total expenditures for hospital review by

Professional Standards Review Organizations.

The new regulations assign to PSROs instead of fiscal intermediaries the responsibility for making cost determinations. Fiscal intermediaries are private insurance companies that handle the processing of claims for services delivered under Medicare. Currently, delegated review costs are reimbursed by Medicare fiscal intermediaries for the full amount of reasonable costs incurred by a delegated hospital.

PSROs use two methods of hospital review—delegated review and non-delegated review. In the former, the PSRO delegates review to hospitals which it finds capable and willing to perform such activities. In the latter, the PSRO conducts review activities in situations where the hospital may not be qualified or willing to perform this function.

"HCFA will provide each PSRO with an overall budget for the costs of hospital review in its area," said HCFA Administrator Howard Newman. "Each PSRO will then work with each hospital in its area to develop a specific review budget based on the hospital's review objectives."

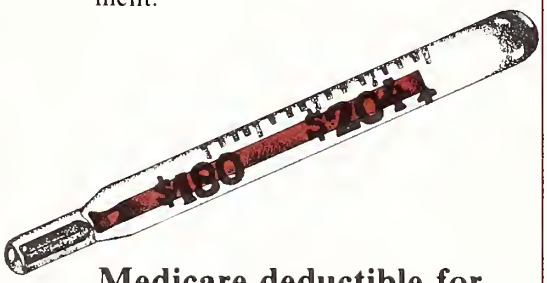
PSROs are composed of local practicing physicians in review organizations across the country. These groups perform reviews to determine the medical necessity, quality and appropriateness of hospital health care services provided to beneficiaries of the Medicare, Medicaid, and Maternal and Child Health programs.

HCFA will furnish each PSRO with a unit cost rate for performance of review. The unit cost will take into consideration regional variations and review priorities and procedures to be used in a given PSRO area. This unit cost rate multiplied by the estimated number of admissions to be reviewed will be the total available funds for hospital review in the PSRO area. The estimated total funds will be the basis

for developing the PSRO's overall review budget.

Under reimbursement for delegated review, the delegated hospital budget and unit cost rate will be based on the specific review objectives negotiated with each hospital and the estimated number of admissions to the hospital under federal programs, the number of admissions to be reviewed, and the manner in which they will be reviewed.

Reimbursement for non-delegated review will be established by the PSRO for each hospital, as part of the PSRO's annual areawide budget. The PSRO will be reimbursed as part of the PSRO's grant unless the non-delegated hospital elected to pay the PSRO for its review activities in the hospital and receive reimbursement.



Medicare deductible for hospital coverage increases to $204

The Medicare hospital insurance deductible has increased from $180 to $204. The increase of 13.33 percent over the 1980 figure is an annual adjustment required by law, in an effort to stay abreast of rising hospital costs.

Roughly equivalent to the average cost of one day in the hospital, the Medicare deductible for a given year reflects the difference between average daily hospital costs for the previous year and the same costs during the base year, 1966. As hospital costs increase and the difference grows, the deductible increases, necessitating higher out-of-pocket payments from Medicare patients.

The rise in the Medicare deductible also increases the amount of coinsurance Medicare beneficiaries must pay, if they remain in the hospital for more than 60 days during 1981.

From the 61st through 90th days of hospitalization, the patient's share is increased from $45 to $51 a day. For stays beyond 90 days, Medicare patients' cost goes up from $90 to $102 a day.

For a stay of more than 20 days in a skilled nursing facility, the Medicare patient pays $25.50 instead of $22.50 toward the cost of the 21st through the 100th day.

About 28.1 million people are covered by hospital insurance under the Medicare program, which is administered by the Health Care Financing Administration. The number is expected to increase to 28.7 million people in 1981. Expenditures for Medicare hospital insurance are expected to increase from $24.3 billion in 1980 to $27.8 billion in 1981.

Prompt notice, review sought for fraud cases

The Health Care Financing Administration has proposed revised regulations to provide timely notice and administrative review when Medicare payments for health care services are withheld because of evidence of fraud.

Current Medicare regulations allow withholding of payments to practitioners, providers or suppliers of services when evidence of fraud exists. They do not, however, require prompt notice of withholding nor do they define what evidence of fraud must be present to justify withholding funds.

"The regulations we are proposing would specify procedures to protect the interest of those who provide services to Medicare beneficiaries," said Howard Newman, Administrator of the Health Care Financing Administration. "Pending investigations would not be compromised, nor would the ability of the federal government to protect funds."

The revision proposes that:

- HCFA instruct carriers or intermediaries to begin withholding reimbursements to providers when there is substantiated evidence that overpayment may be due to fraud and there is a need to protect federal funds. HCFA could delay or waive withholding if it would compromise criminal investigations or legal actions.

- The intermediary or carrier must send a notice to the practitioner or service provider explaining the general reason for the withholding within five days of stopping payment.

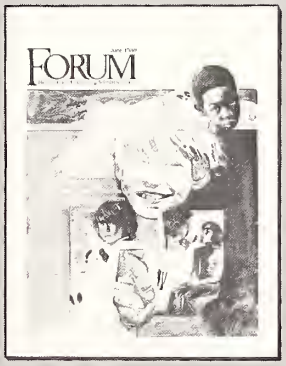
- The Medicare contractor would withhold only the amount of funds required to protect against the estimated overpayment and would repay any funds withheld in excess of the final determination.

- The affected party would have an opportunity to submit facts contesting the withholding; and ordinarily within 13 months, HCFA would either offer an administrative review to determine whether to continue the withholding, or terminate the action and pay the funds withheld.

What's new in health care financing?

HCFA has 3 periodicals to keep you up-to-date...

- **Forum**
- **Review**
- **Perspectives**



Forum
HCFA's official magazine... covers all aspects of health care financing, as well as HCFA's programs and activities...Bi-monthly.

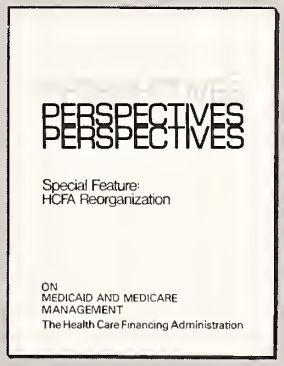
Promotes efficiency within health care delivery systems... serves as a *forum* for discussion and debate on complex health care issues.

Order from: Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402. Annual subscription: $7.50 domestic, $9.40 foreign.

Review
HCFA's research journal... reports quarterly on agency-supported research, demonstration, and evaluation projects...Among research topics covered: physician reimbursement, beneficiary access to services, geographic differences in hospital stays, payment incentives, cost containment.

Also presents statistics on Medicare, Medicaid, national health expenditures, related subjects.

Request a subscription from: ORDS, HCFA, Rm.1-E-9, Oak Meadows Bldg., 6340 Security Blvd., Baltimore, MD. 21235.



Perspectives
HCFA's "how to" publication for Medicaid/Medicare administrators, Medicare carriers and intermediaries, state and local agencies...Published 3–5 times a year.

Articles address program techniques, procedures, operations management...application of research...good practices that are replicable.

Request a free subscription from: Medicaid Medicare Management Institute, HCFA, Rm. 365, East High Rise Bldg., 6401 Security Blvd., Baltimore, MD. 21235.

U.S. Department of Health and Human Services
Health Care Financing Administration

DEPARTMENT OF
HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION
WASHINGTON, D.C. 20201

OFFICIAL BUSINESS

POSTAGE AND FEES PAID
U.S. DEPARTMENT OF HHS
HHS-392

CONTROLLED CIRCULATION