A Study of Hawaii's Medicaid Claims Administration

FINAL REPORT

ARTHUR YOUNG

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Honolulu, HI 96813
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Mr. Clinton T. Tanimura
Legislative Auditor
State of Hawaii
Honolulu, Hawaii 96813

Dear Mr. Tanimura:

It is with pleasure that we submit this final report on a study of Hawaii's Medicaid claims administration. Our study was performed according to the specifications of your office and covered the entire spectrum of claims processing activities performed by the State's Department of Social Services and Housing and the Hawaii Medical Service Association which functions as the State's fiscal agent for the Medicaid program.

Hawaii faces a critical period in the development of a system for providing health care services to the needy. We hope that our analysis and recommendations regarding the administration of the Medicaid claims process will provide guidance to those who must make critical program decisions in the days ahead.

We would like to express our sincere appreciation to you, your staff, and the many individuals in both the Department of Social Services and Housing and the Hawaii Medical Service Association for their cooperation and the time they spent assisting us.

Yours very truly,

Arthur Young & Company

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PART I. INTRODUCTION

A review and evaluation of the administration of a State's Medicaid program is a complex and difficult task. The analysis of the Hawaii Medicaid program required careful scrutiny of the State's policy and program management activities, the claims processing system as operated by the Hawaii Medical Services Association (HMSA), and the many other numerous and diverse associated activities which impact, both directly and indirectly, upon the Medicaid program. Obviously, a review of the type undertaken in the study must focus upon problem areas uncovered and provide recommendations for potential corrective actions that might be available. Furthermore, it must be assumed that the reader of this report has some familiarity with the health care system and the problems of large scale health insurance payment systems. To assist the reader of this report, an attempt has been made to provide the requisite background material in each review area prior to presenting the findings and recommendations. In addition, a discussion of key factors in Medicaid operations is included in order that the recommendations provided are made more meaningful and can be more fully understood within the context of the operation of a Medicaid program. In many instances problems were uncovered which were outside the scope of the study. In those cases recommendations for further study, and the importance of the proposed study, are discussed. Finally, a detailed discussion of potentially useful cost containment strategies is presented.

It is important for the non-expert reader to realize that Medicaid programs throughout the country have generally been extremely difficult to operate. Recent public exposes, and U.S. Senate Finance Committee reports, have brought the problems of Medicaid to the public's attention. Thus, any evaluation of a Medicaid program must be understood within the context of current activities, problems, and achievements by Medicaid programs elsewhere. Although the review focuses upon the problem areas, it must

be understood that many State programs lack the capability and level of achievements now present in the Hawaii Medicaid program. The recommendations are presented with the expectation that they can assist the State of Hawaii in its desire to further improve its Medicaid program.

CHAPTER 1. BACKGROUND OF THE STUDY

This study of the system for administering Hawaii's Medicaid claims was conducted for the Legislative Auditor by Arthur Young & Company. The study was in response to a request of the legislature as expressed in the General Appropriations Act of 1977 (House Bill No. 1, Special Session, 1977). This request was antedated by an earlier Conference Committee Report No. 3, attached to House Bill No. 65, C.D. 1, Fourth Legislature, Budget Session 1968, which directed the Legislative Auditor, "to engage independent medical consultants to conduct an audit of the State's Medical Assistance Program." Among the many issues involved in the 1968 legislative request was the concern for rising costs. As a result a comprehensive audit of the program was conducted. The findings were reported in Audit Report No. 70-3, March, 1970, Audit of the Medical Assistance Program of the State of Hawaii.

One of the major recommendations of that audit was that "a contract be negotiated which would make the HMSA (Hawaii Medical Services Association) the fiscal intermediary for the Title XIX program" (the State's Medicaid program).1/ HMSA in performing Medicaid claims payment and related administrative functions is referred to as the "fiscal intermediary" for the Hawaii Medicaid program. HMSA is a not-for-profit organization whose purpose is to provide health insurance for its subscribers. It also acts as the fiscal intermediary for several governmental health care programs in addition to Medicaid. These programs include Medicare and CHAMPUS, the latter being a federal insurance program for military dependents. In part, the contract between DSSH and HMSA in January of 1971 was a result of the study in 1968. This contract resulted in certain duties being assigned to HMSA as fiscal intermediary. These duties included, in addition to HMSA processing and paying claims for Medicaid services, the following functions: control of the utilization of medical services, performance of financial audits of health care institutional providers, preparation of

periodic reports relating to the program, preparation and distribution of Medicaid identification cards, and performance of other tasks as required under the contract.

After seven years of operations under this agreement, the Legislature requested, as stated in Section 29 of General Appropriations Act of 1977, the "Office of the Legislative Auditor to review the fiscal intermediary contract between the State and HMSA." 2/

The legislative concerns which led to this study of the Medicaid claims administration involve several factors. First, the cost of the contract with HMSA has increased over the years. Second, the cost of the Medicaid program itself has grown faster than other public assistance programs. Finally, there has been widespread publicity in other states about fraud and abuse in administering the Medicaid program.

A. PURPOSES AND SCOPE OF THE STUDY

The study focused upon four areas. First, the study analyzed the provisions of the DSSH/HMSA contract for Medicaid claims administration against the following considerations: (1) conformance to federal requirements and the approved state plan for the Medicaid program, (2) adequacy in providing the framework for the maintenance of an efficient system of claims administration, (3) sufficiency in protecting state interests in such matters as cost control, Medicaid utilization, and prompt and correct payments to providers, and (4) clarity and completeness in defining the duties and obligations of the parties to the contract. Second, the study evaluated the performance of both DSSH and HMSA to determine whether the respective parties are fulfilling their duties and obligations under the contract. Third, the study reviewed alternative approaches for claims administration program control and payment to determine whether changes in currently utilized approaches could make for a more efficient and effective Medicaid program. Included in the review was an evaluation of the extent to which other available sources of payment (e.g, health insurance) for Medicaid recipients is being properly applied prior to charging the program for services rendered. Finally, the study assessed the reasonableness of payments by the Medicaid program to HMSA for contractual services rendered.

In addition to the four major areas identified above, the study also addressed a number of other issues that were specified in the Legislative Auditor's study requirements. 3/ These included:

- The adequacy of processing claims with third party liability, including procedures for identifying such liability, informing parties, and recovering costs.
- The appropriateness of paying physicians on the basis of their "usual, customary, and reasonable" charges.

- How payments for (1) intermediate nursing care, (2) hospital inpatient and outpatient services, (3) skilled nursing care, (4) dental services, and (5) home health care, should be structured to reflect the State's interest in controlling costs, and whether or not the current level of payments for these services is reasonable.

- The effectiveness of the current mechanisms to detect and follow-up on provider and recipient overutilization and investigate and refer for prosecution, where appropriate, fraud or other irregularities.

- Whether or not the payments to HMSA for special administrative services have been correct and proper, taking into account, among other things, HMSA's relationship to other governmental medical care programs.

- Whether or not the information generated by the current system is adequate for planning, programming, budgeting and operational control of key aspects of the program, including assessing the quality of care delivered, and controlling utilization and costs.

B. FORMAT OF THE REPORT

The report is presented in three parts. Part I is an introduction to the study and a description of the Medicaid program for both national and state perspectives. It also describes the program functions of DSSH, HMSA and other state and public agencies as they relate to the Medicaid program.

Part II presents the findings and recommendations regarding administration of the Hawaii Medicaid program. This part includes the examination of eligibility determination, claims processing, provider relations and payment procedures, the management reporting aspects of the claims processing system, the contract between DSSH and HMSA, the planning and budgeting processes and procedures utilized by the program, and the program controls that are currently in use or available to the program.

Part III is a description of alternative cost containment strategies. It contains descriptions of cost control approaches used by other health care programs and provides some insight into the experiences with these approaches. The various alternatives are presented for consideration by the State of Hawaii.

The Medicaid program is quite complex in regard to its rules, regulations and administrative guidelines. In this report an attempt has been made to provide essential background material to assist in understanding the topic under discussion. In order to accomplish this task only the essential and pertinent information regarding Medicaid has been provided. Obviously, it would be impractical, if not impossible, to provide a full and complete description of the specific Medicaid topic in each and every instance. Since the Medicaid program is detailed and documented in the Medicare and Medicaid Guide published and updated periodically by the Commerce Clearing House, Inc., (CCH) Chicago, Illinois, it is assumed that for more detailed explanations and discussion of the topics reviewed in this report the Medicaid CCH reference guides will be utilized to provide whatever necessary additional information or clarification is required.

CHAPTER ONE - FOOTNOTES

1/ Audit of the Medical Assistance Program of the State of Hawaii, conducted by Greenleigh Associates, Office of the Legislative Auditor, Audit Report No. 70-3, March 1970, p. 46.

2/ Section 29, Act 10, SLH First Special Session 1977.

3/ "Specifications for the Study of Hawaii's Medicaid Claims Administration and Instructions for Submission of a Proposal", Office of the Legislative Auditor, State of Hawaii, June 14, 1977.

CHAPTER 2. THE MEDICAID PROGRAM

A. INTRODUCTION

Title XIX of the Federal Social Security Act, which was enacted by the Social Security Act amendments of 1965 (Public Law 89-97), established the federal medical assistance program known as Medicaid. The purpose of Title XIX was to enable states to provide medical services, as necessary, to individuals receiving public money payments including families with dependent children, the aged, the blind and disabled, and to certain categories of persons with low income as defined by the federal law. In addition the program provides other services, such as rehabilitation and post-institutional care, which were included to help individuals attain normal health status. By participating in the Medicaid program the states are eligible to receive federal financial participation (FFP) to offset state expenditures incurred in providing medical and related services to eligible recipients.[1/]

States participating in the program are required to provide medical services to all persons who meet specified federal eligibility criteria. There are two general groups of people who are eligible for medical assistance, the categorically-needy and the medically-needy.[2/] The categorically-needy are those persons receiving or eligible to receive State or federal cash assistance and include persons in families receiving aid for dependent children, the blind, disabled and aged. The categorically-needy are eligible for Medicaid solely as a result of their eligibility for federal and State cash assistance. The eligibility of the second group, the medically-needy, is an option which can be exercised by each individual state. Within this group are individuals whose income and/or resources are too high to qualify as categorically-needy, but who, in the view of the State or territory cannot afford to pay their medical bills. Generally, these persons, were they to pay their medical bills, would then qualify for cash assistance. In order to overcome the situation of making a person indigent

because of personal medical expenditures, the medically-needy program pays a portion of the medical expenses, thereby, keeping the individual from becoming indigent and eligible for cash assistance.

B. A NATIONAL PERSPECTIVE

The Medicaid program, unlike most other federal health programs such as Medicare or the kidney dialysis program, was primarily established by the Congress as a federal/state cooperative effort to improve the health status of the country's indigent population. It was designed to be more than a system for paying for health services. As part of the "new frontier" of the sixties, it was regarded as a means of uplifting the health of the poor by making medical care available to a major portion of the nation's indigent population.

The basic premise of federal/state cooperation was easier to conceptualize than to put into action. Soon after the program was established, states began to express concern about the constraints placed upon them by the enabling federal legislation as well as by the subsequent regulations and administrative edicts promulgated by the United States Department of Health, Education and Welfare (DHEW), the federal agency responsible for administering the program.

Medicaid provides for federal financial participation (FFP) to pay for a portion of health services to the indigent in all states and U.S. territories that agree to abide by federal guidelines. This funding concept made sense politically, economically, and most of all, it was supported on humanitarian grounds. Soon after passage of the enabling legislation, health care providers, bureaucrats, legislatures, and in fact, almost everyone involved with health care geared up to expand the services available to those who would be covered by the program.

At first, it appeared that the FFP would more than make up any additional financial resources needed by the states to meet the growing demand for health care services by those covered by Medicaid, but in the early to mid 1970's it became apparent that Medicaid expenditures were growing at such a rapid rate that the program would literally bankrupt the states were the growth to continue unchecked. In some of the larger states, such as Illinois and New York, the program grew over 1,000 percent in as few as six years.[3/] States realized that they had given up effective control over the program as DHEW and Congress began imposing additional and more specific requirements. In essence the states were locked in to the new program, as it was considered neither financially nor politically feasible to return to the pre-Medicaid level of care for the indigent.

As a result, various state legislatures and executive branches have tried to place cost controls on their Medicaid programs. However, little has been accomplished to date in the way of actually controlling or containing costs.[4/] The program has continued to expand primarily as a result of: (1) an increasing number of eligibles (recipients), (2) additional services being made available, both by federal legislation and state initiatives, and (3) the increasing cost of health services. [5/]

One source of frustration over the inability to control the cost of the Medicaid program is that the program is part of the larger health care system. This means the Medicaid program suffers from all of the health care system's problems that are being brought to the public's attention with increased intensity each day providing a higher level of public awareness.

Rising costs, unrelenting increases in expenditures, public concern, conflicting views, physician and other professionals' anger and frustration, lack of effective controls, absence of a

focused and effective policy, are among the principal concerns that affect the various health programs that exist today. These concerns exist whether the program is Medicaid, Medicare, private insurance, union benefits, prepaid health plans, or any of the other many types and forms of health insurance or benefit programs available.

Given the current circumstances, the concern of the states is understandable. However, before control over the Medicaid program can be established, decision-makers need to understand three crucial points. First, and most important, is the need to understand the Medicaid program within the context of the total health care system.

Secondly, everyone involved in making program decisions must be cognizant of what can and cannot be done within the framework established by federal law and regulation. The federal/state cooperative concept upon which the Medicaid program is based has evolved to the point where the federal government is highly prescriptive regarding numerous operational aspects of the program. In order to participate in the program, states must abide by many complicated, stringent, and often confusing and contradictory requirements established by the federal government.

Third, information must be available that will allow legislators and program managers to assess the performance and identify the specific problems of their Medicaid program. Only with the appropriate information can any state formulate its policy regarding key Medicaid issues, such as:

- What operational controls for improved management are necessary?
- What reimbursement mechanisms can be adopted to moderate the rate of growth in costs?

- What is the proper management role of the state regarding the use of a fiscal intermediary and what responsibilities should be delegated to a fiscal intermediary?
- What are the alternatives to current care mechanisms that should be instituted to make the program more cost effective while still providing essential and appropriate levels of care?
- What program controls over medical services and the placement of recipients at appropriate levels of care are needed?
- How can costs be controlled? If services must be reduced to reduce costs, what optional services should be dropped or curtailed and what will be the resulting impact? Also, what alternate services are available that are more cost effective?

These questions are not unique to Hawaii. Most states face the same problems as program costs rapidly rise and, in some jurisdictions, fraud and abuse increase.

C. THE HAWAII MEDICAID PROGRAM

Hawaii has participated in the Medicaid program since its inception in 1966. According to the data obtained from DSSH, total gross Medicaid expenditures in Hawaii have expanded from approximately $6.6 million in the first year of operation (fiscal year 1966-67) to over $75 million in fiscal year 1976-77. This represents an overall growth of over 1,000 percent in 11 years. The increase in net program expenditures for medical and health services between fiscal years 1974-75 and 1975-76 was approximately $10.1 million or 19.0 percent, and between fiscal years 1975-76 and 1976-77, the increase was approximately $11.9 million or 19.0 percent. (See Exhibit 2.1).

As in other states, it must be presumed that the growth in the cost of Hawaii's Medicaid program has occurred because of the increased number of eligibles and expansion of services, as well as the increasing cost of health care.[6/] The number of eligibles in Hawaii increased from 24,087 in 1967 to 93,247 in 1977, an increase of 287.1 percent.[7/] Since the program is designed to meet the health care needs of those who are eligible, an increase in the number of eligibles results in the delivery of more services and, hence, higher program costs. The relationship between the number of eligibles and the number who actually receive services, however, varies and causes program costs to vary based on the nature of the recipients' medical needs. The cost of providing health care to program recipients depends on their health status, age, and sex. Thus, an increase in the number of those eligible for the program does not necessarily result in a directly related increase in program expenditures.

In Hawaii, the Medicaid program provides the mandated services required by federal law. In addition, the program provides certain optional services that are not mandated by federal regulations.

A number of services have been added to the Hawaii program since the introduction of the program. Some of the services added have included intermediate nursing home care, podiatry services, and early and periodic screening, diagnosis and treatment (EPSDT) for persons less than 21 years of age. The addition of these services, no doubt, has been contributory to the growth of the program's costs. These services are shown in Exhibit 2.2.

Four health care services account for a major portion of the total program expenditures. Hospital inpatient care, skilled nursing home care, physician services, and dental services account for 22.5, 21.4, 20.0, and 10.6 percent of the total expenditures in fiscal year 1976-77, respectively. An optional service, inter-

mediate nursing care, ranks fifth in expenditures and accounts for eight percent of the total. Expenditures in each general category of service for the last two years are shown in Exhibit 2.3.

To fully appreciate Hawaii's Medicaid program, it is necessary to compare it with national experiences. However, such comparisons must be tempered because there are significant differences in the various states' Medicaid programs including the services provided, the reimbursement rates used, and the groups covered. There are also significant variations in the methods used to calculate costs. Hence, any such comparisons should always be viewed as general and not precise comparative indicators of state expenditures. Hawaii eligibles comprise approximately 10.3 percent of the State's total permanent population,[8] compared to the 1976 national average of 10.7 percent.[9] The national average expenditure per Medicaid recipient in 1976 was $610,[10] while in Hawaii it was $637.[11]

One of the reasons for this difference in average program expenditure per eligible recipient is the higher program expenditures for the aged category in Hawaii. In 1976, Hawaii's expenditures for services rendered in the aged category averaged $2,411 per recipient per year [12] while the national average was $1,371 [13] per recipient per year. In addition, expenditures for the aged category represents 31.4% [14] of the total Hawaii Medicaid program as compared to a national average of 19.1%. [15]

Another factor to be considered in Hawaii is the higher utilization of more expensive skilled nursing care as contrasted to the lower utilization of less expensive intermediate nursing care. This is the opposite of the national experience.[16] In Hawaii, intermediate nursing home care represents a significantly lesser proportion of care provided to Medicaid recipients. In 1976, Hawaii's total expenditure for intermediate nursing home care

was 7.4% of total program expenditures [17] while the national average was 15.2%. [18] In comparison, expenditures in Hawaii for more expensive skilled nursing home services was 24.4% [19] of the total while nationally it was 18.2%. [20]

An important contributory factor to the increases in Hawaii's Medicaid program expenditures is the impact of the medically-needy category. Coverage of this group, the medically-needy, is an option which was chosen by Hawaii at the inception of the program. This group becomes eligible for Medicaid because their income and/or resources are insufficient to pay their medical bills.[21] Therefore to be a recipient of medically-needy assistance an individual must by definition have incurred significant medically related expenses. As a result, this category of recipients has placed a major burden upon the Medicaid program expenditures such that the program costs for covering this group is disproportionately larger than their percentage of the total Medicaid recipient population. Furthermore, this optional medically-needy group has expanded faster than the mandated categorically-needy population.[22]

In 1977, the medically-needy accounted for approximately 9% of the covered population, but consumed approximately 13% of the program's total expenditures. This growth experience in population and expenditures is depicted in Exhibit 2.4.

D. THE ORGANIZATION AND RESPONSIBILITIES WITHIN THE HAWAII MEDICAID PROGRAM

The Department of Social Services and Housing (DSSH) is the State Agency responsible for administering the Hawaii Medicaid program. DSSH interacts with a number of other state agencies, the federal government and the Hawaii Medical Services Association (HMSA) in fulfilling its administrative responsibilities. Within DSSH, the Medical Care Administration Service (MCAS), under the

Public Welfare Division (PWD), has direct responsibility for administration and coordination of the program. The Income Maintenance Branch Offices, which are also under the PWD, are responsible for determining the public assistance eligibility of indigent persons.

In terms of administrative responsibilities, MCAS is the State entity which develops, implements and interprets policy as it relates to the Medicaid program. It is also responsible for maintaining the various program documents used to communicate operating policies and procedures. MCAS is responsible for keeping these documents up to date and in compliance with the federal requirements. Additionally, MCAS is responsible for administering the contract with the fiscal intermediary, HMSA.

To carry out its activities MCAS has 12 full time and 3 part time authorized positions [23/] which include positions for professional medical personnel (physicians, dentists, pharmacists, and nurses) as well as general management and support personnel.

The other major organizational offices within DSSH which are directly involved in the Medicaid program are described below. The functions described below represent the consultant's observations as to their current activities.

- Administrative Services Office (ASO) - ASO provides accounting, auditing of benefit payments, budgeting and printing services to MCAS.
- Office of Information Services (OIS) - OIS provides data processing services including systems design, programming, computer program maintenance, and computer data control services to MCAS. OIS is responsible for operating and maintaining the computerized Case Information Control System (CICS), which processes eligibility information.
- Program Evaluation Office (PEO) - PEO has the responsibility to conduct periodic quality control reviews of the eligibility determination process.

- Research and Statistics Office (R&S) - R&S is responsible for preparing periodic reports for DHEW and for maintaining program statistics.

The functional organization of DSSH as it relates to the Medicaid program is shown in Exhibit 2.5.

In fulfilling its responsibilities, MCAS must coordinate the efforts of a number of other state departments. The principal departments, in addition to DSSH, which are involved to any substantive degree in the Medicaid program are as follows:

- Department of Accounting and General Services (DAGS). DAGS' primary responsibilities related to the Medicaid program are to perform audits on paid provider claims, to maintain a file of paid claims, reimburse the fiscal intermediary (HMSA) for its administrative costs, to provide funds for HMSA to pay medicaid claims, and to review the financial transactions of the program.

- Department of Budget and Finance (B&F). B&F assists MCAS in preparation and evaluation of the Medicaid budget. It also provides limited systems and programming support.

- Attorney General (AG). The AG's office is primarily involved in issuing legal opinions in support of the Medicaid program and conducting fraud investigation and prosecution.

- Department of Health (DOH). DOH is involved with the Medicaid program as a provider of various medicaid services. DOH provides hospital services and long term care facility services to Medicaid recipients by means of its role in the State/county hospital system. As such it is directly reimbursed by the Medicaid program as a provider. DOH also acts as the administrator of the EPSDT program on behalf of MCAS.

HMSA is the fiscal intermediary for the Hawaii Medicaid program. As such it operates as an agent for the State of Hawaii. Its responsibilities include: payment of claims submitted by health care service providers, maintenance of various necessary

programmatic controls, establishment of reimbursement rates, issuance of recipient identification cards, preparation of reports related to the operation of the program, and interaction with the providers of medical services. HMSA is also responsible for operating and maintaining the automated claims payment and control information system referred to as the Hawaii Medicaid Management Information System (HMMIS). A full summary listing of the duties of HMSA and DSSH, as specified in the contract, is provided in Exhibits 2.6 and 2.7.

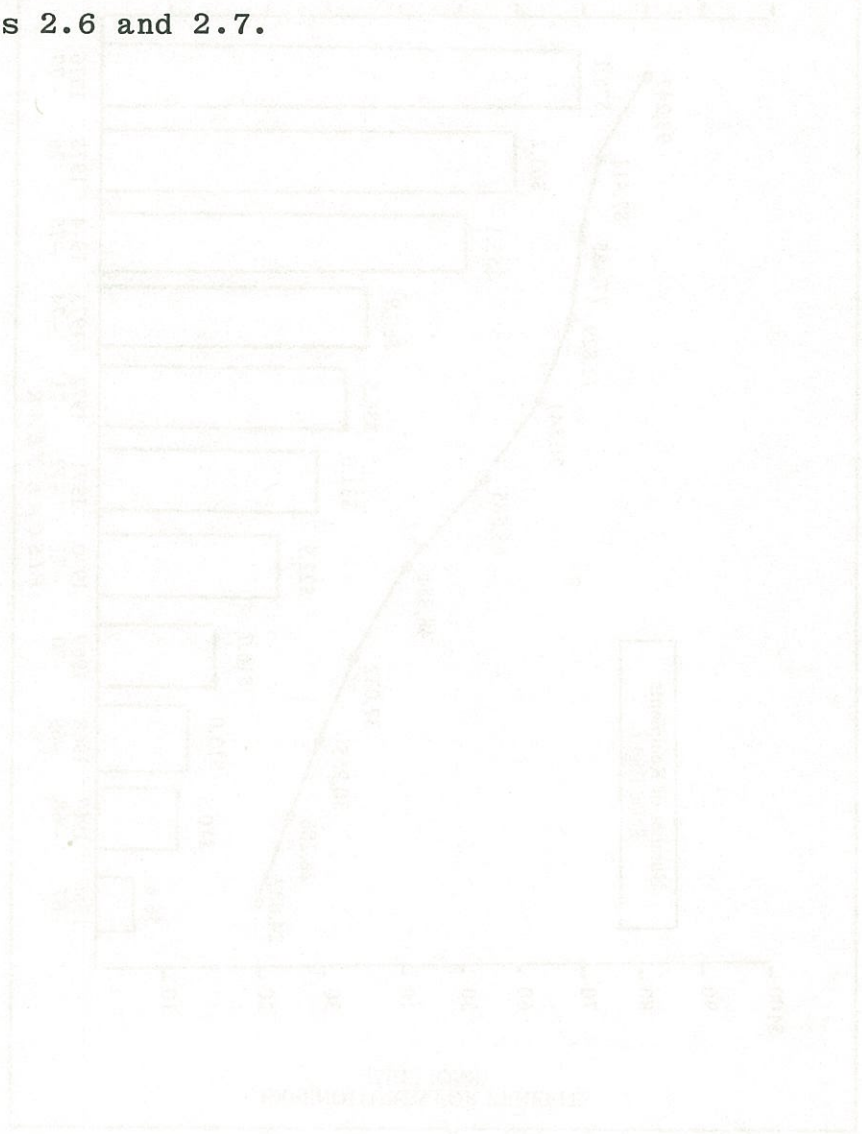
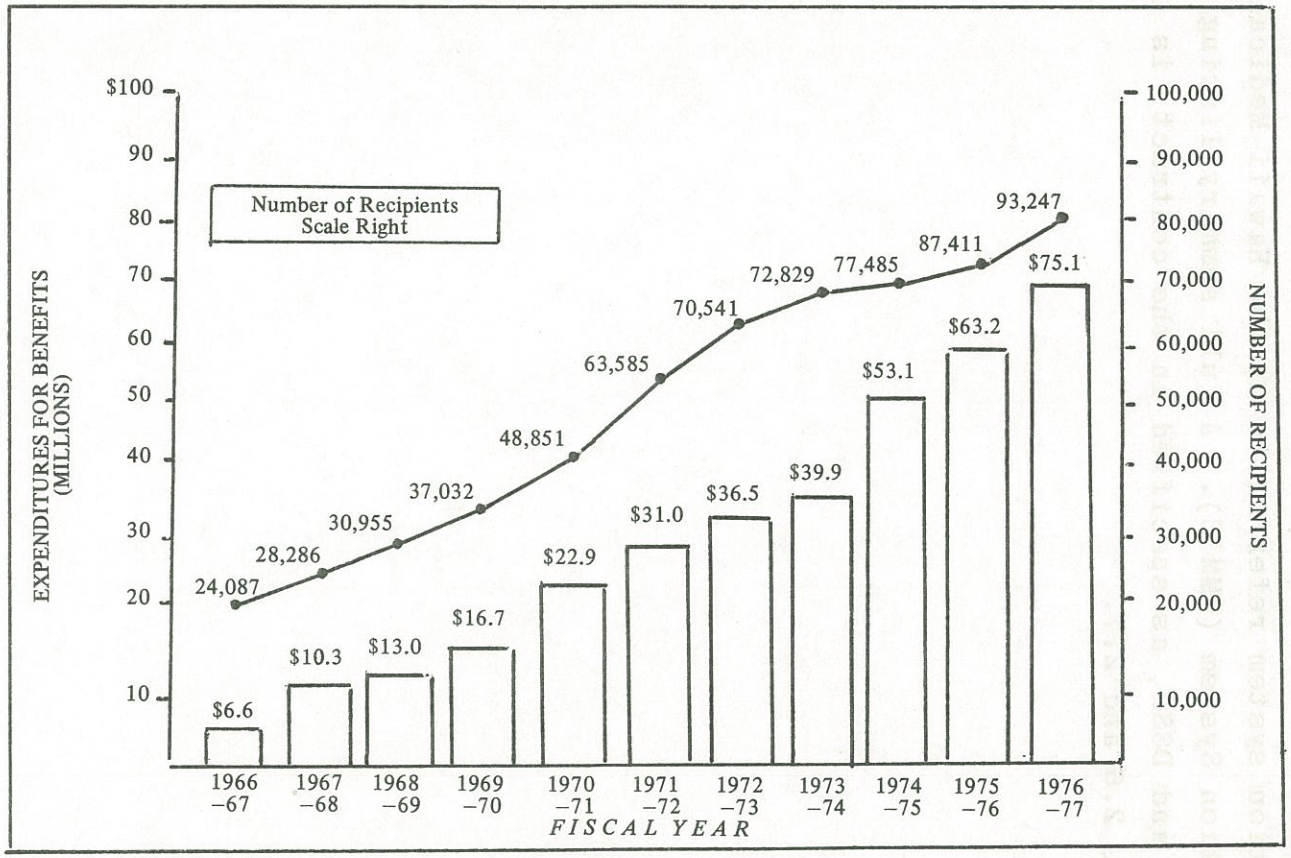


EXHIBIT 2.1
EXPENDITURES AND RECIPIENTS BY FISCAL YEAR (FY)
FOR THE HAWAII MEDICAID PROGRAM
1967 TO 1977



Source: DSSH, Medical Care Administration Service.

EXHIBIT 2.2
HAWAII MEDICAID SERVICES
(* Added since program inception)

FEDERALLY REQUIRED SERVICES:

1. Inpatient hospital services (other than services in an institution for tuberculosis or mental diseases).
2. Outpatient hospital services.
3. Other laboratory and x-ray services.
4. Skilled nursing facility services (other than in an institution for tuberculosis or mental disease) for individuals 21 or older.
*5. Early and periodic screening, diagnosis and treatment of physical and mental defects for individuals under 21.
*6. Family planning services and supplies.
7. Physicians' services rendered in the office, patient's home, hospital, skilled nursing home, or elsewhere.
8. Transportation of recipients to and from providers of services.

OPTIONAL SERVICES

*9. Intermediate care facility services.
10. Home health services furnished by home health agency and supplies.
11. Other diagnostic, screening, preventive, and rehabilitative services.
12. Clinic services.
13. Dental services.
14. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or an optometrist, whichever the patient may select.
15. Physical therapy and related services.
*16. Podiatry services.

Sources: CCH, p. 6232
Hawaii Medicaid State Plan

EXHIBIT 2.3

HAWAII MEDICAID PROGRAM EXPENDITURES
BY TYPE OF SERVICE

	Fiscal Year 1975-1976		Fiscal Year 1976-1977	
		% of Total		% of Total
Hospital Inpatient	$12,115,590	22.8%	$16,107,702	22.5%
Nursing Home Care	12,986,718	24.4	15,328,542	21.4
Physician Services	9,179,729	17.3	14.298,031	20.0
Dental Services	5,416,523	10.2	7,573,473	10.6
Intermediate Care	3,917,990	7.4	5,687,653	8.0
Drug	3,998,060	7.5	4,755,888	6.6
Hospital Outpatient*	2,258,314	4.2	2,980,255	4.2
Lab and X-ray	1,522,423	2.9	2,304,270	3.2
Family Planning	797,419	1.5	1,299,772	1.8
Other Care **	627,065	1.2	790,380	1.1
Home Health	157,417	0.3	216,768	0.3
Screening Services	168,076	0.3	200,208	0.3
Total Expenditures	$53,145,324	100.0%	$71,542,942	100.0%
Patient's Share of Medical Bill	2,817,321		3,285,182	
Expense Covered by Patients' Medical Insurance	2,135,611		3,229,132	
TOTAL EXPENDITURES OF SERVICES	$58,098,256		$78,057,256	

*Includes Hospital Clinic Services.

**Includes Vision Care, Medical Supplies, Transportation, and other minor services.

Sources: HMSA, Medicaid Report, July 1, 1975-June 30, 1976, p. 12; and HMSA, Medicaid Report, July 1, 1976-June 30, 1977, p. 15.

EXHIBIT 2.4
COMPARISON OF MEDICALLY NEEDY
BY PERCENTAGE OF TOTAL MEDICAID
POPULATION AND EXPENDITURES

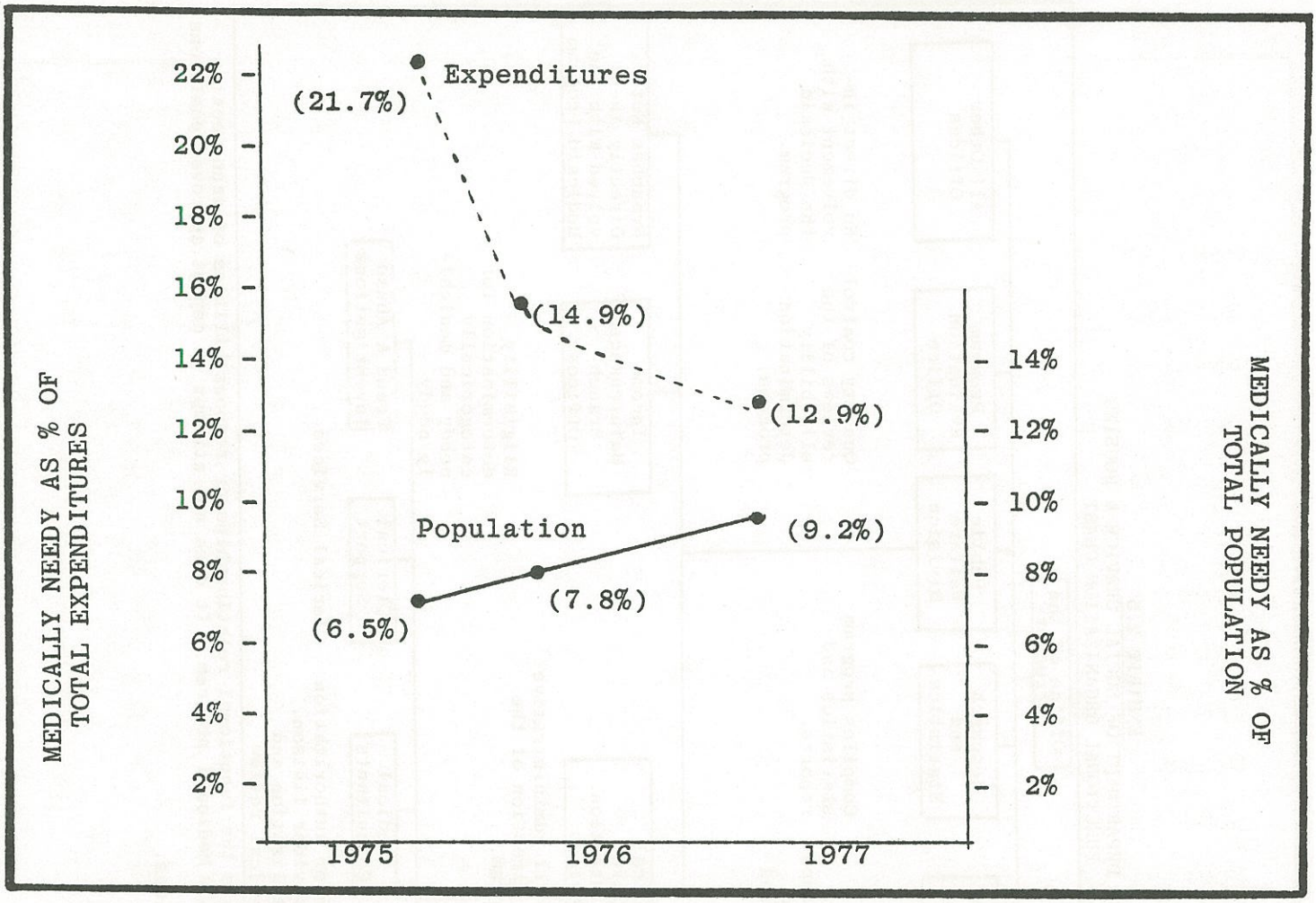


Exhibit 2.4 Shows the growth in % of total population and expenditures for the medically needy category. See text for full discussion

Source: Compiled from data in: Medicaid Report - 1975, pp. 5, 11; 1976, pp.4, 10; and 1977, pp. 9, 14.

EXHIBIT 2.5
THE DEPARTMENT OF SOCIAL SERVICE & HOUSING
FUNCTIONAL ORGANIZATION CHART

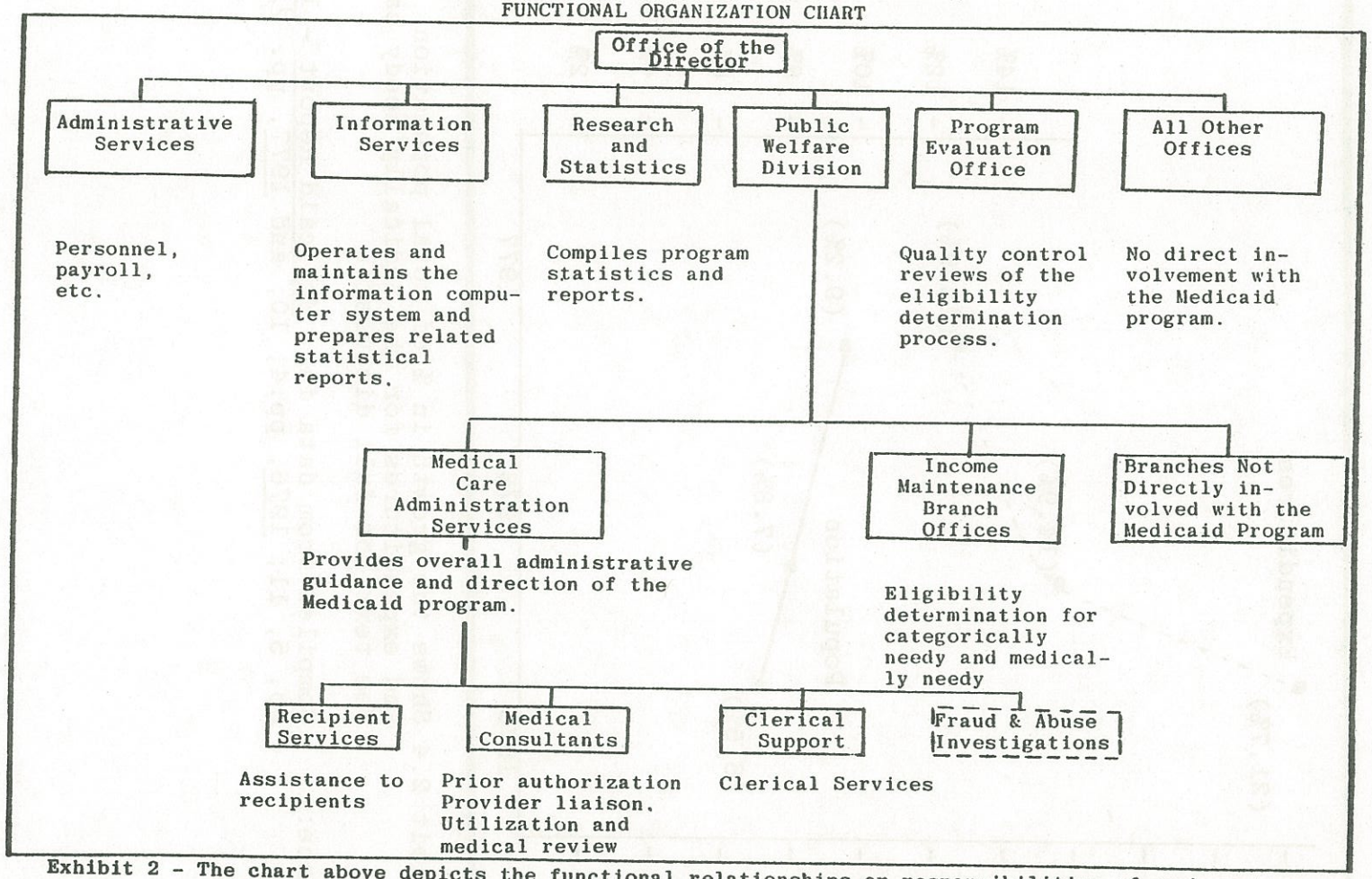


Exhibit 2 - The chart above depicts the functional relationships or responsibilities of each section that interacts with the Medicaid program. It does not attempt to depict approved positions lines of authority.

Source: Consultants' observations.

EXHIBIT 2.6 -- SUMMARY LISTING OF DUTIES OF THE FISCAL INTERMEDIARY (HMSA) UNDER THE CONTRACT

1. Advise and assist the State Agency (DSSH) in carrying out the State Plan.
2. Prepare informative material on the nature of the program.
3. Distribute the informative material to providers.
4. Develop forms for claims by providers.
5. Distribute forms to providers interested in the program.
6. Receive claims from eligible providers for services to eligible persons.
7. Determine whether claims comply with DSSH regulations.
8. (a) Determine whether prior authorization is needed for a claim and, if so, whether it was obtained; (b) determine the amount to be paid determined on a reasonable cost or reasonable charge bases.
9. Use appropriate data processing procedures to: audit claims per specified procedures; reject claims not payable under the Plan or regulations; and notify the provider of any rejection.
10. Approve for payment all claims that are eligible.
11. (a) Pay all valid claims within 20 days; (b) for services payable on a reasonable cost basis, make payments judged to be reasonable on an interim monthly basis and on an annual audited basis.
12. Prepare for DSSH invoices to cover payments made by HMSA per 11 above.
13. Assist DSSH in applying safeguards against fraud and abuse.
14. If fraud or abuse is suspected, withhold payment and assist in recovering payment.
15. (a) Assist DSSH in establishing liason with the providers and others; (b) establish procedures for resolving disputes between providers and HMSA and between HMSA and eligible persons.
16. Assist providers and DSSH in developing and applying procedures for utilization control.

continued ....

17. Advise DSSH of all complaints from eligible persons, refer all requests for fair hearings to DSSH, and take part in the hearings as needed.
18. Provide all accounting, statistical and cost information as specified in the contract.
19. Provide any reports requests by DSSH, with costs reimbursible by DSSH.
20. Notify DSSH of the date of death of any eligible person.
21. Develop a manual on HMSA's operation under the contract.
22. Develop and apply procedures for providers to use other sources of payment permitted under the Plan.
23. Maintain records that DSSH needs as provided in the contract.
24. With permission of DSSH, subcontract to another a part of the services to be provided under the contract.
25. Make audits of eligible providers.
26. Issue identification cards to eligible persons (added in Addendum 8 to contract).

Source: XIX Contract for administration of medical assistance with HMSA

EXHIBIT 2.7 -- SUMMARY LISTING OF THE DUTIES OF THE STATE AGENCY (DSSH) UNDER THE CONTRACT.

1. Determine who is eligible for care under Medicaid.
2. (Deleted by Addendum 8 to contract).
3. Continually provide HMSA with listings showing the eligibility status of eligible persons.
4. Advise eligible persons about the benefits to which they are entitled.
5. Advise eligible persons about the need to identify themselves to providers.
6. Inform HMSA of the liability of persons for authorized benefits "as medically indigent."
7. Provide HMSA with all current regulations applicable to the State Plan.
8. Provide HMSA with information regarding eligible providers who have been terminated or suspended from the program.
9. Promptly pay HMSA invoices for payments to providers and for administrative expenses.
10. Promptly pay HMSA for its administrative expenses on a monthly basis, as specified.
11. Cooperate with HMSA in carrying out its responsibilities specified in the contract.
12. Provide HMSA with the names of persons authorized to act for DSSH.
13. Indemnify the HMSA and its personnel in any judicial or administrative action that arises from its carrying out its functions under the contract, unless the HMSA's liability is the direct consequence of criminal conduct, gross negligence, or fraud.

Source: XIX Contract for administration of medical assistance.

CHAPTER TWO - FOOTNOTES

1/ "The Medicare and Medicaid Guide," Commerce Clearing House (hereinafter cited as CCH), July 1976, p. 6031.

2/ 45 Code of Federal Regulations, Section 248.1 (hereinafter cited as 45 CFR 248.1), State Plan Requirements and Options for Coverage under the Medical Assistance Program.

3/ Chapters 7, 8, 10, Lessons for National Health Insurance, A. Spiegel & S. Podair, Aspen Systems Corporation, Rockville, Maryland, 1975.

4/ Section III, ibid.

5/ Section II & III, ibid.

6/ Section II, ibid.

7/ 1967 figure from Bob Millar, Administrator, MCAS Section, DSSH.

1977 figure from Medicaid Report for the State of Hawaii, July 1, 1976 to June 30, 1977, HMSA, September 1, 1977 (hereinafter cited as Medicaid Report-1977).

8/ Medicaid Report - 1977, p. 11.

9/ Calculation based on 22.9 million recipients in FY 1976 (Medicaid Management Reports - Annual Report, Fiscal Year 1976, Medical Services Administration, Health Care Financing Administration, U.S. DHEW) (hereinafter cited as Medicaid Management Reports - 1976), p. 12; and estimated total Resident U.S. population in 1976 of 214.7 million (statistical abstract of the U.S. Census Bureau).

10/ Medicaid Management Reports - 1976, p. 14.

11/ Basis for calculation of 1976 average Hawaii expenditure per eligible: (1) average number of eligible recipients in 1976 assumed to be 83,408 (average of beginning and ending eligibles) (Medicaid Report - 1976, p. 5); (2) total expenditures are the sum of total benefits paid for the year, $53,145,000 (Medicaid Report - 1976, p. 10).

12/ Medicaid Report - 1976, calculation using data on pp. 6, 10.

13/ Medicaid Management Reports - 1976, p. 14.

14/ Medicaid Report - 1976, calculation using data on p. 10.

15/ Medicaid Management Reports - Annual Report, Fiscal Year 1976, calculation using data on p. 16.

16/ Medicaid Management Reports - 1976, p. 9.

17/ Medicaid Report - 1976, p. 12.

18/ Medicaid Management Reports - 1976, p. 9.

19/ Medicaid Report - 1976, p. 12.

20/ Medicaid Management Reports - 1976, p. 9.

21/ 45 CFR 248.1(d) coverage of the medically needy; or CCH, p. 6101.

22/ The medically-needy group increased by 25% between 1976 and 1977, as compared with 5% for the categorically-needy. Medicaid Report - 1976, p. 4, and 1977, p. 9.

23/ Verbal communication with Bob Millar, Administrator, MCAS, DSSH.

PART II. PROGRAM ADMINISTRATION

This part of the study reviews the administration of the Hawaii Medicaid program. It includes a discussion and analysis of the Medicaid state plan, the contract between DSSH and HMSA, and the Hawaii Public Welfare Manual.

An important aspect of Medicaid administation is the determination of eligiblity for the program. The eligibility process, duties and responsibilities of the State, and control requirements are evaluated.

To a major extent, the effectiveness and efficiency of a Medicaid program depends upon the supporting automated claims processing system. Therefore, a significant portion of this part addresses the Hawaii Medicaid Management Information System.

It is self-evident that any public program must maintain close cooperative relationships with the providers of services. In the Medicaid program, which is highly dependent upon the private health care sector, this is especially important. In this part of the study, this administrative responsibility is discussed.

Finally, the controls on utilization and information which are available to or used by the Hawaii Medicaid program are presented.

CHAPTER 3. FEDERAL ENVIRONMENT FOR MEDICAID

This chapter addresses the requirements imposed upon the Hawaii Medicaid program by the federal government. The Social Security Act, as amended, is the governing federal law for the Medicaid program. That Act established the public assistance system in the states and the conditions under which the federal government will share in the cost of providing assistance to needy persons. Since the passage of the Social Security Act in 1935, numerous amendments have broadened, redefined, and strengthened the program of assistance for the needy.

A. FEDERAL MEDICAID LEGISLATION

In 1965, legislation provided for two new broad health programs to be added to the Social Security Act: Title XVIII - Medicare, which is basically a health insurance program for the elderly, and Title XIX - Medicaid, which is a program of providing health care for indigent persons. Since Medicare is a federally administered program, this study did not attempt to review Medicare except where it impacted directly upon the state Medicaid program. Soon after passage of the 1965 amendments, Congress recognized that the Medicaid program was not proceeding according to Congressional intent. Congressional concern focused on two areas: (1) that a very large and substantially unlimited federal liability would arise under the law as originally written, and (2) that the Medicaid program was being used in some states to assist persons with near-average income, thereby duplicating available private health insurance and other protection which these individuals might obtain for themselves.[1/]

As a result of these concerns, amendments to the Social Security Act were passed in 1967 which placed certain restrictions on program participation by the states, allowed the states to purchase Medicare coverage for certain Medicaid-eligible citizens,

and placed more stringent restrictions on the federal matching of state funds. 2/ This legislation marked the initial attempt at imposing controls over state participation in the Medicaid program. These and later amendments to the Social Security Act have typically been directed toward imposing a greater degree of federal control over the program, causing greater financial burden on the states, and reducing the flexibility states had over their individual Medicaid programs. A summary of the major amendments that have had an impact on the Medicaid program is provided in Appendix B.

The enactment of the federal Medicaid program resulted in a complex set of rules and regulations to ensure that the intent of Congress was promulgated and that sufficient controls could be established. To ensure compliance with these requirements the federal government has introduced numerous federal sanctions which can result in withholding of varying amounts of federal financial participation.

B. THE STATE PLAN FOR MEDICAID

Background

The State Plan is a comprehensive statement developed by the Department of Social Services and Housing describing the nature and scope of the Hawaii Medicaid program. Each state participating in the Medicaid program is required by federal law to have a state plan. The Medicaid State Plan must contain all information necessary to DHEW to determine whether the State's program will operate as required by Title XIX and promulgated regulations.

The State Plan is basically the road map by which the Medicaid program operates within the State. It documents which health care service options the State will offer, specifies the nature and

extent of controls placed upon the program, describes the methods and resources used to administer the program, indicates what groups will be covered by the program and to what extent, and assures DHEW that the State is ready, willing and able to participate in the program. Once the State Plan has received the necessary approvals, it becomes the overall governing document of the State's Medicaid program.

In addition to the State Plan, there are numerous program rules and regulations, policy manuals, program documents, procedure manuals, forms, etc. It is imperative that there be consistency between the State Plan and all program documentation.

Findings

The consultants reviewed the contents of the Hawaii state plan and evaluated whether the plan was consistent with the actual operations of the Medicaid program. A thorough analysis of federal requirements was undertaken to determine the degree of compliance with federal rules and regulations.

Inasmuch as the State Plan is the governing document of the State Medicaid program, it is essential that it be kept up-to-date in regard to federal and State program changes. This is a federal requirement of federal regulation 45 CFR 205.5(a). The State Plan also mandates that "the Plan will be amended whenever necessary to reflect new or revised federal statutes or regulations, or material changes in any phase of State law, organization, policy or State agency operations."[3/]

Maintaining a complete and accurate Medicaid State Plan is the responsibility of the Medical Care Administration Service (MCAS), of the Department of Social Services and Housing (DSSH).

The present State Plan was analyzed and compared with the federal requirements as well as its consistency with Medicaid operational and policy documentation. Numerous inconsistencies and inaccuracies were observed. These are discussed below.

- Description of Covered Services

  The review indicated that the State Plan inaccurately describes the services which are covered by the Hawaii Medicaid program. One important inconsistency was found.[4/] Currently, the program does provide reimbursement for podiatry services. Conference Committee Report 3 attached to S.B. 1295 (Act 218, SLH 1973) directed DSSH to include podiatry services in the medical assistance program. Act 80, SLH 1973 permitted Medicaid recipients to choose either a podiatrist or a physician in seeking medical services. Also, Section 3448.1 of the Public Welfare Manual indicates that podiatry is a service included in the Hawaii Medicaid program.

- Explanation of Cost-sharing Responsibility by Recipients

  The State Plan does not contain an explanation of the requirements for the medically-needy to share in the payment of their medical services.[5/] In Hawaii, the medically-needy recipients are required to pay a portion of their medical expenses. This sharing requirement is called co-payment. Federal regulations allow the state to require such sharing by the medically-needy. In Hawaii, this requirement is imposed only to the extent that the individuals have excess income and resources over and above the level which would make the person eligible for cash assistance payments. This cost sharing requirement is detailed in section 3417.6 of the Public Welfare Manual. Yet, no mention of this requirement or method of calculation is present in the State Plan.

- Requirements for Prior Authorization

  Many services require that the provider receive permission from the program before treatment is given to the recipient in order to receive payment for the services rendered. This requirement for the provider to receive payment is termed "prior authorization or approval."

The prior authorization requirements as shown in Exhibit 3.1A to the State Plan are not the same as the prior authorization requirements as currently imposed by the program or as shown in the manuals of instructions for providers (Provider Manuals). [6] The numerous inconsistencies related to prior authorization are summarized in Exhibit 3.1.

- Statement of Duties and Responsibilities

The State Plan is required to specify the duties and responsibilities of the numerous participants in the operation of the State Medicaid program. [7] An evaluation of this was undertaken to determine whether the duties and responsibilities as prescribed in the State Plan were consistent with those found in current practice. It was found that in many instances there were major inconsistencies between activities performed and those expressed in the State Plan.

The State Plan indicates that MCAS is to participate in the negotiation of provider rates. In practice, this has been done solely by HMSA. HMSA performs this function through the process of provider audits and analysis of provider charges with no participation by state officials.

The State Plan indicates that MCAS is responsible for monitoring the fiscal intermediary's activities. These responsiblities include evaluating the adequacy of HMSA's performance in the areas of claims review and processing, furnishing periodic administrative information, and auditing HMSA's Medicaid fiscal operations. Inasmuch as neither DSSH nor any other state agency has ever audited or reviewed HMSA operations, it appears as though this responsibility is not being carried out as described in the State Plan.

Recommendations

Obviously, state officials, legislators, providers, program administrators, and all other interested parties must rely upon written documentation concerning the Medicaid program under a myriad of circumstances. Discrepancies among various documents, inaccuracies, and omissions can only result in confusion, inefficiencies, and operational mismanagement. It is incumbent upon MCAS to exercise all possible care and diligence to ensure that the documentation is adequately maintained.

It is recommended that:

1. The Medicaid State Plan be updated and made consistent with the requirements as established by federal and state laws and regulations.

2. The State Plan be modified to reflect current policy and procedures and to reflect proper activities of the program.

3. An administrative procedure be developed for continually monitoring and updating the State Plan and other program documentation.

C. FEDERAL REQUIREMENTS RELATING TO THE CONTRACT WITH THE HAWAII MEDICAL SERVICES ASSOCIATION

Background

A major and critical function of any Medicaid program is the payment of claims for services rendered to Medicaid recipients.

The complexity of the claims payment process requires many additional operational activities, among the more important of which are the following:

- Operation of an automated claims payment system.
- Control of payments for services to ensure that they are reasonable, proper, and within the scope and limitations of the program.
- Provision of operational and administrative reports.

Since these operational activities are complex, the federal Medicaid regulations provided that states could choose to contract these activities to a non-state organization. The outside organization which would perform these functions is referred to as the fiscal intermediary (FI).

Under federal regulations a contractual agreement is required between the state and the fiscal intermediary. The federal reguations specify the following:

1. The contract shall be in writing.

2. The contract period shall be specified.

3. The contract shall specify the functions of the contractor.

4. The contract shall specify the population covered by the contract and the procedures for enrollment and re-enrollment of that population.

5. The contract shall specify the amount, duration, and scope of the medical assistance to be provided.

6. The contract shall provide that the agency and DHEW have the right to inspect and/or evaluate the quality, appropriateness and timeliness of the contractual services and the right to audit and inspect the books and records of the contractor pertaining to services perfomed and payments made under such contract.

7. The contract shall establish provisions and criteria for extension, renegotiation and termination of the contract. The termination procedures must require contractor to promptly supply information necessary for reimbursement of claims outstanding at the time of contract termination.

8. The contract shall provide that the contractor establish and maintain a record system for services rendered to Title XIX (Medicaid) enrollees and that records will be preserved for the time period specified by the Secretary of DHEW.

9. The contract must provide that the contractor shall conform to the confidentiality of information requirements regarding eligible recipients.

10. The contract will specify how third party liability transactions will be handled by the contractor and state agency.

11. The contract will specify when functions undertaken by the contractor may be done under subcontract and that no subcontract can terminate the legal responsibilities of the contractor.

12. The contract will include termination procedures requiring contractor to promptly supply all information required for payment and related information systems. If contractor has proprietary rights to this material, contracts and subcontracts must provide for offering the material to the state to either purchase, lease or buy the use of the material including:

- Computer programs
- All necessary data files
- User and operations manuals and other documentation
- System and programs documentation
- Training programs for the agency and their agents or representatives for use in operations and maintenance of the system.

13. The contract must establish the amount to be paid the contractor for performing the required functions, the basis for the amount of payment, and when the payment will be made.

14. The contract must provide that payment will be made to providers in accordance with the guidelines specified by the regulations.[8/]

Federal participation in payments to a contractor shall be available only for the period when a contract meeting all these requirements is in effect. DHEW may withhold funds if it is found that either party has substantially failed to perform according to these requirements. 9/

Findings

The current DSSH/HMSA contract was compared with the above federal requirements to determine the degree of compliance. Numerous instances of non-compliance were noted.

- Termination Procedures The contract does not adequately specify termination procedures. There is no definition of contractor and DSSH rights to termination. Thus, there are no provisions for critical items such as transfer of data, payment of open invoices, appeals or other disputes, concluding financial statements, and other final status reports.

  Perhaps more importantly, no provision has been made for acquisition of the computer programs and related documentation that are essential to continued operation of the State Medicaid program.

  Finally, the contract provides that HMSA may charge an amount for termination operations which could be inconsistent with those charges and/or costs made by HMSA for ongoing operations. The contract states that should termination procedures be instituted by the State, HMSA may at its own discretion charge the State other than on a cost basis. 10/

- Confidentiality Requirements. The contract does not specify that HMSA will conform to the confidentiality of information requirements regarding the disclosure of recipient information, according to federal and state laws and regulations.

- Basis of Payment to Providers. Federal regulations require that the contract specify the basis by which providers will be reimbursed for services rendered. The DSSH/HMSA contract is incomplete inasmuch as the payment basis is not specified for the following covered services:

- Laboratory and x-ray services
- Early and periodic screening, diagnosis and treatment
- Family planning
- Intermediate nursing care facilities
- Other diagnostic, screening, preventive and rehabilitative services
- Clinic services
- Therapeutic services (speech, occupational and audiological)
- Podiatry

The basis for payment of inpatient hospital care, skilled nursing facilities, dentists' services, physicians' services, home health care, complicated conditions, and optometry services, are specified in the contract.

Payment for inpatient hospital care and skilled nursing facilities are identified in the contract as being based on the institutions' usual, customary, and reasonable cost charged private patients.[11] This is in conflict with the State Plan which reflects the federal requirements that after December 31, 1973, payment for hospital services will be the "lesser of reasonable cost or customary charges."[12] Federal regulations changed the method of paying for skilled nursing services from the usual, customary, and reasonable cost basis identified in the contract to the lesser of reasonable cost or customary charges as of July 1, 1976.[13]

HMSA and DSSH Duties and Responsibilities. Federal regulation requires specification of contractor duties and responsibilities in the contract. The provisions in the contract are inaccurate and inconsistent with those currently performed by HMSA. For example, recently (September 1, 1977) HMSA assumed responsibility for prior authorization. However, there is no mention of this important responsibility in the contract.

The numerous inconsistencies and inaccuracies in the contract cited above clearly indicate that the contract does not accurately define the DSSH/HMSA relationship. The consultants found that the

operating relationship is in actuality defined by numerous informal documents, memoranda, and letters. Many of these informal additions and modifications have not been incorporated in the contract document. Additionally, no review has been undertaken by DSSH to ensure that these informal transmittals are consistent with federal and state requirements.

Recommendations

The interrelationship between fiscal intermediary and the State Medicaid program is complex and fraught with opportunity for misunderstanding, omissions in fulfilling responsibilities and duties, and possible improprieties. Furthermore, large amounts of State and federal funds are involved. The public demands accountability and legislators reflect this concern by requiring that all such arrangements be clearly defined and properly documented. Only in this manner can the public be protected and federal and state monies be properly utilized. As important as the above may be, it is also necessary to protect the participants (DSSH and HMSA) by clearly documenting their respective roles and responsibilities. Furthermore, in such a large activity which involves millions of public dollars and public support of the poor, there is a need to ensure that there is no appearance of wrongdoing. Consequently, it is imperative that all due care be exercised in documenting and defining roles and responsibilities. This generally means that the two parties establish a clear, accurate and meaningful contractual document.

It is recommended that:

1. The necessary evaluation methods, controls, and criteria be established to ensure that all federal and state regulatory requirements are met.

2. The termination aspects of the contract be revised to conform to federal regulations with specific emphasis on the State's rights related to the automated claims processing system, related data, files, documentation, etc., and protection for both parties in respect to termination payments.

3. The contract specify that HMSA conform to federal regulations on confidentiality of information.

4. The basis of payments and reimbursement for services to recipients be listed in the contract in such a manner that they are proper, complete, and in accordance with federal requirements.

EXHIBIT 3.1

DIFFERENCES IN PRIOR AUTHORIZATION EXPLANATIONS IN PROGRAM DOCUMENTATION FOR SELECTED PROCEDURES AND SERVICES

	PROGRAM DOCUMENTATION		
PROCEDURE/SERVICE	PROVIDER MANUALS	STATE PLAN	PUBLIC WELFARE MANUAL+
Hospital Services	Any elective admission to hospital for treatment requires prior authorization. (P. IV-11)	Specifies length of stay requiring prior authorization. (Att. 3.1-A Suppl. (1))	Specifies length of stay requiring prior authorization. (Sec. 3455)
Dental Services	Specifies 30 procedures requiring prior authorization. (P. IV 24, 25)	Specifies prior authorization required when the total cost of Dental services exceeds $50, except for emergencies. (Att. 3.1-A Suppl. (10))	No reference. (Sec. 3445)
Podiatrist Services	Specifies services to patients confined in hospitals requires prior authorization. (P. IV-11)	No explicit reference to Podiatrists	Specifies services costing more than $25 require prior authorization. (Sec. 3448.1)
Skilled Nursing Facilities	No reference	Specifies prior authorization is required. (Att. 3.1-A Suppl. (4-a))	No reference. (Sec. 3446)
Neuro-Psychiatric	Specifies in patient services require prior authorization. (P. IV-11)	No reference	No reference
Medical Procedures	A specific list of procedures is identified as requiring prior authorization. (pp. IV-11, IV-20, 21)	Specifies any non-emergency admission - e.g. for elective surgery - requires prior authorization. No specific list. (Att. 3.1-A Supp. (1))	Specifies non-therapeutic sterilization (Sec. 3449) and all podiatrist services more than $25 (Sec. 3448.1) require prior authorization
Contact Lenses	Specifies contact lenses excluded unless authorized by DSSH Medical Consultant. (P. IV-18)	Specifies contact lenses are excluded. (Att. 3.1-A Suppl. (12-d))	Specifies contact lenses covered only in limited conditions and require prior authorization. (Sec. 3444.3 (2) and (3))
Laboratory Procedures	No reference	Specifies prior authorization required for procedures costing more than $25. (Att. 3.1-A Suppl. (3)).	No reference
Rental or Purchase of Supplies	Specifies supplies costing more than $25 or more than $25 if calculated at a monthly rate for period of need. (p. IV-11)	Specifies prior authorization is required. (Att. 3.1-A Suppl. (7-c))	Specifies supplies costing more than $25 or those needed more than 7 days require prior authorization. (Sec. 3444.2 (3))

Exhibit 3.1 - A table describing the prior authorization requirements for selected procedures and services as found in the Medicaid Provider Manuals, the State Plan, and Public Welfare Manual. See text for explanation.

+ Sec. 3454 indicates DSSH "may" require prior authorization for all deferrable "Medical Services," which is defined to include: Physican services; Dental services; Admission to Hospitals & Skilled Nursing Facilities; Surgical procedures; Psychiatric care; and Purchase/Rental of equipment and supplies

Sources: Medicaid Provider Manual, pp. IV-11 through IV-25.
Hawaii Medicaid State Plan, Attachment 3.1-A and supplement.
Hawaii Public Welfare Manual, Sec. 3454 through Sec. 3463.

CHAPTER THREE - FOOTNOTES

1/ CCH, p. 6040.

2/ CCH, p. 6041.

3/ Hawaii Medicaid State Plan (hereinafter cited as State Plan), Section 7.1.

4/ State Plan, Attachment 3.1A, p. 2, Section 6a.

5/ State Plan, p. 19a, paragraph 4.18b(2).

6/ Medicaid Provider Manual, February 1976 (hereinafter cited as Provider Manuals), pp. IV-11 through IV-25.

7/ 45 CFR 205.101, Organization for Administration.

8/ 45 CFR 249.82 or CCH, pp. 8466 through 8468.

9/ 45 CFR 249.82(d) or CCH, p. 8470.

10/ Title XIX Contract for Administration of Medical Assistance (hereinafter cited as HMSA Contract), p. 29.

11/ HMSA Contract, pp. 14, 15; State Plan, Attachment 4.19A.

12/ 45 CFR 250.30(b)(1) "Inpatient hospital services"; or CCH, p. 8505.

13/ 45 CFR 250.30(b)(6) "Skilled nursing and intermediate care services"; or CCH, p. 8507.

CHAPTER 4. THE STATE REQUIREMENTS FOR MEDICAID FISCAL INTERMEDIARY OPERATIONS

The Hawaii Medicaid program is governed not only by Federal laws, rules, and regulations, but also by State law. The Federal rules, regulations and laws give the states some latitude with their Medicaid programs by requiring each state to promulgate its own rules, regulations and laws directed toward supporting and further defining portions of the program.1/

In this chapter the DSSH/HMSA contract is reviewed for compliance with Hawaii law. In Hawaii, the Hawaii Revised Statutes (HRS), Title XX - Social Services, Chapter 346, is the law generally governing the Medicaid program. Chapter 103, HRS, dealing with public contracts is also applicable because of the contractural relationship with HMSA. Also in this chapter, similar contracts from other states are compared to the DSSH/HMSA contract.

A. STATE REQUIREMENTS FOR THE CONTRACT WITH HMSA

Background

The laws of Hawaii require specific procedures to be followed in the awarding of public contracts. Since the DSSH/HMSA contract is between the State and a non-governmental entity, particular attention to State contracting requirements is necessary.

Findings

1. Competitive Bidding Requirements

Hawaii revised statutes specify both the requirements for competitive bidding and advertising for State contracts in excess of $8,000 and exceptions to these requirements. One exception is for purposes that, "do not admit of competition," which has traditionally included contracts for professional services and purchases from a sole source. 2/ Inasmuch as the contract with HMSA is

automatically renewed each year and is in excess of $8,000 the services HMSA provides are not specifically exempted from competitive bidding. Since the services are largely administrative in nature, they do not follow those categories traditionally exempted.

2. Bonding Requirements

The Hawaii Revised Statutes relating to Expenditure of Public Money and Public Contracts states, "Before any contract is entered into, the party with whom the contract is proposed to be made shall give security for the performance thereof by a good and sufficient bond conditioned for the full and faithful performance of the contract in accordance with the terms and intent thereof and also for the prompt payment to all others for all labor and materials furnished by them to him and used in the prosecution of the work provided for in the contract, which bond shall be in an amount equal to fifty percent of the contract price or of the cost of the work as previously estimated by the State or county, whichever is higher." 3/ (Emphasis added).

The contract specifies that the contractor maintain a bond in an amount to be decided upon by DSSH, but not in excess of $50,000. The contract specifies a fidelity bond rather than a performance bond as required by law. 4/ It should be noted that the amount paid to HMSA for fiscal management duties for fiscal year 1976-1977 was in excess of $1.4 million. The fidelity bond currently maintained by HMSA is $600,000, clearly exceeding the amount requirements of the contract; however, no performance bond is maintained by HMSA.

3. Payment for Dental Services

According to Section 346-59, HRS, dentists are to be paid their "usual and customary fees up to the maximum which federal rules permit." However, the current HMSA contract indicates that dental services are paid on the basis of a fixed-fee schedule. The contract, therefore, is not in conformance with State law.

Recommendations

Competitive bidding, properly administered, can promote a healthy environment for improvement in performance and obtaining an optimal system at a reasonable cost to the State. Traditionally, states have required the posting of performance bonds to ensure protection of the States' interest. However, in such activities as required by a fiscal intermediary, these requirements should be tempered to promote acquisition of services in the best interests of the State.

It is recommended that:

1. HMSA be required to post a performance bond or make other such provision for recourse commensurate with the State's financial exposure in relation to the administrative costs of operating the program.

2. HMSA's contract be revised to require provision of a Fidelity Bond commensurate with the funds involved for payment of claims. The amount of the bond should be based upon the State's exposure. The contract should be specific in this regard.

3. Medicaid fiscal intermediary contracts be periodically put to bid on a competitive basis. Since it would not be in the best interest of the State, nor could any organization be reasonably expected to operate as a fiscal intermediary on only a single year's basis, it is suggested that the contract resulting from competitive bidding be for periods of at least three years and an option, to be exercised by the State to extend the contractural term for an additional two years based upon performance, be included in the contract.

4. The contract be revised to conform with State law pertaining to payment for dental services.

B. OTHER CONTRACT DEFICIENCIES

Background

HMSA, in addition to paying claims also is required by the contract to perform special administrative services. 5/ For example, HMSA is required to prepare special reports for DSSH and the Hawaii legislature, perform extended studies of program operations, undertake analysis of claims to ferret out fraudulent and abusive practices, and perform many other services which they are called upon to undertake from time to time. HMSA also by contractural agreement is responsible for auditing institutional provider cost reports upon which reimbursement is based. 6/ All of these activities usually require a budget for resources and manpower as well as a plan of action in order to accomplish the required work. This budgeting function is imperative both for the fiscal intermediary's internal operations and for the State's control over expenses to be incurred by the fiscal intermediary. Since the State is required to reimburse the fiscal intermediary for its costs, the review, comment, and in certain instances, the approval of the State is a reasonable approach for the State to manage its needs and expenditures for these services.

The availability of sufficient computer safeguards is usually a requirement to assure that there will be a continuing ability to process provider claims accurately, protect against the loss of data, and to ensure maintenance of control over program transactions.

The processing of claims lends itself to the establishment of specific performance evaluation criteria (i.e., number of claims processed by type during a specific time period, cost per claim processed, time to process a claim, error rates, etc.). These criteria can be used as indicators of performance by the fiscal intermediary as well as Medicaid managers to determine the adequacy of claims processing operations.

Findings

1. Review of the HMSA contract discloses that no provision has been made to budget for or control the costs incurred by HMSA when undertaking special administrative services or provider reimbursement and audit tasks. Thus, there is no basis for determining in advance the probable cost for non-routine work such as modifying the computer programs to produce additional management reports.

2. No provision is made in the contract for the maintenance of back-up computer files, programs, or hardware nor does the contract specify the recovery methods to be used in case of systems failure or disaster. The contract does not require HMSA to arrange for a back-up computer system to be used in case their system is inoperable for an extended period.

3. With few exceptions, the contract is silent regarding the measurement of performance. There are no standards for evaluation of any aspect of HMSA's performance except the specification that HMSA pay all valid claims within 20 days.

Recommendations

It is in the best interests of both parties to establish a means for evaluating performance as well as to develop reasonable controls over the cost of special administrative services and provider audit work. The State must have assurance that it can participate in managing and controlling all public expenditures. The fiscal intermediary requires protection against unreasonable criticism for its activities after it has undertaken a specific operation which may prove costly. Procedures are required which allow the State to request essential services in a manner which is equitable and fair to the fiscal intermediary so these services can be delivered to the State for a reasonable and minimal cost.

It is critical to the maintenance of proper computer operations to provide appropriate back-up and recovery equipment and procedures. The potential for incurring exhorbitant costs for the State exists without such safeguards.

It is recommended that:

1. The fiscal intermediary be required to establish budgets for all special administrative services and provider audit work. For activities costing in excess of a specified amount or falling within certain operational categories (i.e., major system modifications) the State should have review and prior approval authority. For minor non-routine activities in order to alleviate burdensome administrative requirements the State should exercise only review and comment responsibilities.

2. DSSH require HMSA to establish systems back-up capability and disaster recovery procedures to safeguard the computer system, the computer programs, and the data files.

3. DSSH and HMSA immediately undertake the development of equitable performance criteria and a plan of action to initiate ongoing performance review.

C. COMPARISON WITH OTHER FISCAL INTERMEDIARY ARRANGEMENTS

Background

The Hawaii fiscal intermediary contract was compared to contracts from the states of Arizona, Alabama, Arkansas, California, Virginia and Vermont. This review revealed the following information.

Findings

1. The contracts from the other states generally had a greater degree of specificity in defining (a) contractors and state

duties and responsibilities, (b) termination procedures, (c) identification of applicable State and Federal laws and regulations, (d) the requirements, reports, and components of the computer systems, and (e) quality control requirements, allowable error rates, and error procedures. For example, the methodology for controlling and collecting monies from sources other than the recipients who have responsibility for payments on behalf of Medicaid eligibles (such as insurance, accident benefits, employee compensation benefits, etc.) is not specifically described in the Hawaii contract. Yet, this important aspect is to be found in all of the other contracts reviewed.

2. HMSA is reimbursed for its cost in performing fiscal intermediary functions by the DSSH. 7/ The contract provides that HMSA will receive reimbursement for all routine costs incurred in association with performing its duties up to a limit of $1.17 per claim. HMSA has full discretion for the incurrence of expenses which are then reimbursed by the State. These expenditures can be made without regard to the impact on effectiveness and/or efficiency under the terms of the present contract. A provision protecting the state's interests is an important component of most fiscal intermediary contracts reviewed. For instance, Alabama provides different rates to the FI based upon the level of effort required, i.e., drug claims which required a lesser effort than hospital claims were reimbursed at a lower rate than hospital claims. The contracts in Vermont and Virginia set a specified fixed price for the fiscal intermediary. In the Arkansas contract, changes to the automated claims processing system require state approval as to the costs incurred.

Recommendations

Cost related contractural agreements is one method of providing the states with a means of participating in the control of expenditures by the fiscal intermediary. In Hawaii, these controls are

lacking and the potential exists for HMSA to pass on to the State any and all costs.

It is recommended that:

1. DSSH review other states' contracts for their specificity in defining contractual obligations, and revise the State's contract accordingly.

2. DSSH determine a method of reimbursement which provides reasonable safeguards over the level and nature of costs incurred by HMSA.

3. DSSH require prior approval for any and all changes to the automated claims processing system.

CHAPTER FOUR - FOOTNOTES

1/ Indicative of the latitude permitted the states are the following examples: 45 CFR 246.10 (a) (3), State plan requirements and options for coverage under the medical asistance program; 45 CFR 248.1(c), options for coverage of the categorically-needy; C45 (FR 248.1(d), coverage of the medically-needy; 45 CFR 249.10, amount, duration and scope of medical assistance.

2/ Section 103-22, HRS.

3/ Section 103-34, HRS.

4/ HMSA contract, P. 28.

5/ HMSA contract, PP. 10. 51-53.

6/ HMSA contract, PP. 9, 48-50.

7/ HMSA contract, P. 25 Item D.

CHAPTER 5. RECIPIENT ELIGIBILITY FOR THE MEDICAID PROGRAM

Background

A critical facet of the Medicaid program is the determination of who is eligible to receive Medicaid benefits. It is imperative that an effective and efficient system exists to ensure that only those persons meeting the State and Federal eligibility requirements receive services.

The determination of eligibility is a complicated process based upon numerous criteria. The responsibility for determining eligibility rests with the Income Maintenance Branch Offices under the Public Welfare Division of DSSH. Once eligibility for either categorically-needy or medically needy is determined, MCAS through the fiscal intermediary is required to pay for medical services rendered to the eligible person. Thus, eligibility determination and payment for medical services are two distinct, albeit interrelated, operational activities.

The Public Welfare Division has units throughout the State to determine the eligibility of the individuals who apply for the various public assistance programs. DSSH also has special units to assist persons to establish eligibility specifically for the medically-needy program. These special units were set up as a separate function because of the complex nature of determining eligibility for the medically-needy program.

The Public Welfare Division establishes eligibility through applications and interviews with prospective eligible persons. Once an individual has been determined eligible for Medicaid, he or she is considered to be a "client" of the department. Client information is entered into the Case Information Computer System (CICS) of DSSH.1/ On a weekly basis CICS produces a computer tape listing of all persons who are eligible to receive Medicaid benefits.

This tape is forwarded to HMSA and serves as the means for HMSA to identify eligible persons.

Once determined to be eligible, an individual remains eligible until his or her financial status no longer meets the eligibility criteria. Recipients are required to notify their DSSH caseworker in the event of a change that might effect eligibility status. DSSH also is required to verify the eligibility of each recipient periodically. The eligibility of categorically-needy recipients is to be reviewed every six months and the status of the medically-needy annually. However, under Aid to Families with Dependent Children (AFDC) a person no longer eligible for cash assistance retains Medicaid benefits for a period of four months. 2/ For the aged, blind or disabled, this Medicaid grace period is extended to the second month following ineligibility. 3/ In the case of the medically-needy no such extension period is available.

The Public Welfare Manual states that face-to-face interviews are to be conducted between caseworkers and potential clients as part of the initial eligibility process, but is silent regarding the need for personal contact during recertification.

Nationwide concerns with eligibility determination procedures, and reports and studies which showed large numbers of ineligible persons receiving public assistance prompted DHEW to establish requirements for the state to implement a Medicaid Eligibility Quality Control (MEQC) program by July 1975. 4/ The regulations also specifically define the sampling and review procedures to be used in making the quality control tests as well as the form of the report.5/

In Hawaii, the MEQC function has been assigned to the Program Evaluation Office of DSSH. At the time of this study, three quality control reviews have been conducted and a fourth is in progress.

Findings

Information utilized for eligibility determination is collected either on the DSSH application form personally prepared by the applicant or by the DSSH caseworker who obtains supplemental data to the application form via phone calls, mail or interviews with the applicant. Interviews are conducted solely at the DSSH Branch Office. The application form is the primary means by which eligibility determination data is collected.

During the review, it was noted that the eligibility determination application form is deficient regarding the scope of the applicant waiver. One major purpose of the waiver is to allow DSSH to collect information required to verify applicant eligibility for public assistance programs. The current waiver does not provide DSSH sufficient latitude to independently verify data contained in property tax, motor vehicle, department of labor, or other similar public records.

Under the current DSSH procedures followed in all eligibility determination offices, visits to applicants' homes by the caseworkers responsible for determining eligibility are not normally made, even on a sample basis. Data from applicants regarding assets, earnings and so forth are obtained through the mail and personal interviews. Interviews with caseworkers indicated that there is no consistent policy regarding whether or not face-to-face interviews should be a part of the process of reviewing or recertifying the eligibility of recipients. It is estimated that between 25 and 50 percent of those recertified as eligible are interviewed. Typically, in those cases not receiving interviews, data is collected by mail or phone. In essence DSSH has a policy of accepting the information received from applicants at face value. Unfortunately, data are not available to assess the possible impact of this practice on eligibility errors.

The Public Welfare Manual identifies the type of financial data that is to be gathered to determine initial and continuing eligibility.6/ However, DSSH does not verify the data about the applicants' financial status and other criteria through a process which would provide for cross checking with available independent sources. In other words, information such as home value is checked only when the applicant declares that he or she owns a home. Marital status, property tax assessment, motor vehicle, and other available records are not checked to verify data obtained from applicants.

The process of eligibility determination is further hampered by a high degree of inconsistency noted in the organization and content of client and applicant files. During the review of client files found in eligibility determination offices, on the outer islands and Oahu, it was noted that the documentation contained in the files, including bank confirmations, verification of employment status and verification of assets, was either totally missing or filed in such a manner as to make the data very difficult to locate. This inconsistent approach to collecting and filing information makes a uniform approach to eligibility determination difficult and time consuming, if not impossible. In an attempt to overcome this problem, one Oahu branch developed its own checklist for assuring proper inclusion of data in its files. This checklist is not used by other branches.

Because of the large number of eligible recipients, applications for eligibility, and redeterminations of eligibility, a voluminous amount of data must be maintained, updated and verified. This can only be accomplished in an effective, efficient and timely manner by the use of a supportive computerized information system. The Case Information Computer System (CICS) was installed by DSSH to serve this purpose.

One major deficiency in the current information system is the unavailability of complete client data records. For instance, the CICS is not structured to provide comprehensive client information for a client who is enrolled in more than one public assistance program. Thus, when a client has multiple problems (e.g., the need for medical assistance, food stamps, and financial assistance) the caseworker must obtain three separate records regarding the client.

An additional operational problem with the CICS is the lack of timeliness of processing client information. The system does not readily accept in a timely fashion client information from field offices: such as, address changes, status changes, employment, additional resources, etc. Therefore, timely adjustments to client records are not made. On the outer islands, caseworkers cited cases in which as long as two months have been required to make an address change or to change eligibility status.

Delays in providing valid, up-to-date information have resulted in an unknown number of incorrect issuances of identification cards by HMSA because of their reliance on the eligibility tapes furnished by DSSH.

Not all field offices have their own computer terminals to directly input client information. The procedure that is followed for offices without computer terminals is to obtain the necessary information from their clients and send the information to an office that does have a terminal. The originating office must then wait until a computer printout of a complete data record containing the original input data is received. Then the originating office makes any corrections required and re-inputs the data through an office with a terminal, thereby, necessitating a repeat of the process.

A further processing delay is caused by the equipment and operating system used to input data from the field offices. The terminals used must be connected directly to the DSSH central

computer in order to input data. The number of connections available during the day is limited, causing the input clerks to wait for varying periods until a connection is available.

The problems of eligibility determination have been recognized in Hawaii as well as nationally. Error rates, where they can be meaningfully identified, have been quoted as high as 40 percent in some public assistance programs. In the AFDC program, the national average error rate as calculated by DHEW was 26.7 percent for the last six months of 1975. Major urban states tend to have higher rates and more rural states lower rates. For example, New York's rate for that period was 44.0 percent, whereas, Utah's was 15.7 percent. Hawaii's reported rate for that period was 35.0 percent.

Federal regulations require face-to-face interviews with all clients who are selected for an eligibility quality control testing procedure in order to measure errors in the eligibility determination process. 7/ Hawaii has undertaken a quality control evaluation since 1975. The results of those reviews are shown in Exhibit 5.1 and 5.2.

Exhibit 5.1 demonstrates the dollar impact on the Medicaid program from October 1975 to September 1976 of the eligibility determination errors. The errors shown include (1) errors that resulted in ineligible recipients inappropriately getting program benefits, (2) errors that resulted in over payment of claims as a result of payments for services by the State which should have been paid by other responsible parties, and (3) errors caused by recipients overpaying their share of the cost.

This data shows that for the eighteen months between October 1975 and March 1977, the program overpaid an estimated $1,696,700 and overcharged recipients some $66,200 with a net error of $1,630,500.

Exhibit 5.2 shows the causes of the errors uncovered through the quality control reviews by DSSH during the period October 1975 through March 1977. The reported cause of errors identifies DSSH as responsible for 61.3 percent of the errors and the recipient errors for 38.7 percent, a ratio of 1.6 to 1. This means that for every error traceable to a recipient-related error, DSSH makes 1.6 errors. 44.7 percent of the total errors are traceable to the failure of caseworkers to take indicated action such as following up to verify information that affects eligibility.

In the planned corrective action portion of the quality control review reports of DSSH, 8/ suggestions are provided for DSSH to take corrective action. Exhibit 5.3 provides a listing of the problems as identified by DSSH and the planned corrective action.

Recommendations

The fiscal intermediary is impacted by the eligibility process in two major ways. First, the number of eligibles for which payment is required is a result of the eligibility process as undertaken by DSSH. Second, the weekly tape of eligibles is the critical element in assuring that HMSA pay claims on behalf of DSSH only for eligible persons. It can be readily seen that eligibility errors impact sufficiently on the operations of the fiscal intermediary to require close and continual scrutiny by the State.

It is recommended that:

1. DSSH review the eligibility determination process to ensure that sufficient data is collected and verified in determination of recipient eligibility.

2. The application forms be revised to include the appropriate waivers thereby allowing DSSH to collect data necessary for eligibility verification.

3. An analysis be made of the feasibility of installing computer input terminals in all DSSH branch offices. The terminals should have the capability of transmitting and receiving data during low usage periods (such as at night), and should be equipped with a printer. This type of terminal is referred to as a remote batch terminal.

EXHIBIT 5.1

THE POTENTIAL DOLLAR IMPACT IN THE MEDICAID PROGRAM OF ELIGIBILITY DETERMINATION ERRORS

Result of Error	Quality Control Report For Period:	Types of Claims: Institutional Error Rate	Institutional Dollar+ Value of Errors	Non-Institutional Error Rate	Non-Institutional Dollar+ Value of Errors	Total Estimated Impact on Program+
Benefits paid for ineligible persons	Oct. '75-Mar. '76	1.5%	$ 2,013	5.5%	$ 159	$ 437,300++
	Apr. '76-Sep. '76	2.0%	593	7.1%	96	153,000
	Oct. '76-Mar. '77	4.3%	2,843	5.5%	85	426,900
						$1,107,200
Overpayment of claims	Oct. '75-Mar. '76	19.5%	$ 1,096	3.9%	20	$ 162,200++
	Apr. '76-Sep. '76	20.1%	1,968	3.2%	103	316,700++
	Oct. '76-Mar. '77	19.4%	1,040	6.2%	71	200,600
						$ 679,700
		Estimated Gross Overpayment				$1,696,700
Underpayment of claims	Oct. '75-Mar. '76	14.1%	$(163)	-	$ -0-	$(20,600)++
	Apr. '76-Sep. '76	12.8%	(91)	.6%	(10)	(24,400)
	Oct. '76-Mar. '77	5.8%	(99)	.7%	(8)	(21,200)
						(66,200)
		Estimated Net Impact of Errors				$1,630,500

Exhibit 5.1 This exhibit describes the dollar impact upon the Medicaid program as a result of errors in the eligibility determination process. A complete discussion of the method used can be found in the DSSH quality control reports.

Source: Medicaid Quality Control Semi-Annual Report for Q.C. Review Period October 1975 to March 1976, DSSH, July 1976; and subsequent reports for review periods April 1976 to September 1976, and October 1976 to March 1977.

+ The amounts shown are from Table 5 of the respective DSSH Quality Control reports identified above.

++ Number differs from Table 5 in source due to computation error in Table 5 of the source.

EXHIBIT 5.2

CAUSE OF ERRORS IN THE ELIGIBILITY PROCESS

	PERIOD & NUMBERS OF INCIDENTS IN SAMPLE COVERED BY QUALITY CONTROL+			TOTAL NUMBER OF ERRORS IN SAMPLE (230)	
I. DSSH ERRORS	Oct. '75-Mar. '76	Apr. '76-Sept. '76	Oct. '76-Mar. '77	Number of Errors(1)	% of Errors to total errors(230)(2)
A. Failure of eligibility worker to take indicated action, such as follow-up	23	33	47	103	(44.7%)
B. Arithmetic error	6	7	4	17	(7.4%)
C. Other	7	6	8	21	(9.1%)
	36	46	59	141	(61.3%)
II. CLIENT ERRORS					
A. Failure to report change in circumstances	27	18	13	58	(25.2%)
B. Reported incorrect or incomplete data	7	17	7	31	(13.5%)
	34	35	20	89	(38.7%)
III. TOTALS					
A. Total errors	70	81	79	230	(100.0%)
B. The % of claims in error from the total sample of claims	22.2%	22.3%	20.8%	21.8%*	

Exhibit 5.2 The exhibit portrays the various causes of errors in the eligibility determination process as uncovered by a DSSH study. See text for explanation.

Source: Medicaid Quality Control Semi-Annual Report for Q.C. review period October 1975 to March 1976, DSSH, July 1976; and subsequent reports for review periods April 1976 to September 1976, and October 1976 to March 1977.

+ Data shown in Exhibit extracted from Table 2 (Institutional Stratum) and Table 2 (Non-Institutional Stratum) of the respective DSSH Quality Control Reports.

* Average error rate for total period studied.

EXHIBIT 5.3

CORRECTIVE ACTION PLAN FOR THE
MEDICAID PROGRAM - DEPARTMENT OF SOCIAL SERVICES AND HOUSING
JULY, 1976

PROBLEM	TASK DESCRIPTION
1. Failure to take action a. Reported information disregarded. b. No follow-up on incorrect or inconsistent information. c. No follow-up on impending changes. d. Failure to verify where required by policy.	1. • Establish current caseload, staffing and growth rate. • Develop workload standard. • Evaluate current job priorities. • Evaluate caseworker job series including minimum qualifications, pay, and responsibilities.
2. Incorrect Computation a. Arithmetic b. Allowable Deductions	2. • Review equipment needs, such as: adding machines, calculators, etc. • Review policies and procedures relating to budgeting incorrect resources and deductions. • Develop training program concerning policies and procedures relating to budgeting incorrect resources and deductions.

Exhibit 5.3: A list of problems identified by DSSH and their recommended actions.

Source: Medicaid Quality Control Semi-Annual Report for Q.C. Review Period October 1976 to March 1977, DSSH Program Evaluation Office, July 1977.

CHAPTER FIVE - FOOTNOTES

1/ CICS is an automated information system used for processing and controlling applications, payments, and status of persons covered by public assistance.

2/ For a further discussion, see CCH, pp. 6325-6377.

3/ CCH, pp. 6375-6377.

4/ 45 CFR 250.25, Medicaid eligibility quality control; or CCH, pp. 8498-8499.

5/ 45 CFR 250.25(d), Basic elements of Quality Control System; and 45 CFR 250.25(e), Reporting requirements or CCH, p. 8498.

6/ Hawaii Public Welfare Manual, Sec. 3400 through 3417.

7/ 45 CFR 250.25, Medicaid eligibility quality control; or CCH p. 8498.

8/ Medicaid Quality Control Semi-Annual Report for Quality Control. Review Period October 1976 to March 1977, DSSH Program Evaluation office July 1977 (hereinafter cited as Quality Control Report - October 76 to March 77), p. 7.

CHAPTER 6. THE PROCESSING OF CLAIMS FOR PAYMENT

Expenditures for Medicaid in Hawaii exceeded $75 million in fiscal year 1976-1977. To operate a program as large as Medicaid requires the processing of over one million claims a year. Administering a program of this magnitude requires a complex and comprehensive automated claims processing and information retrieval system. The computer system is the means by which providers (hospitals, doctors, medical suppliers, etc.) can be paid for delivery of authorized services to eligible recipients in an effective, efficient and timely manner. Accordingly, the system must be capable of controlling the processing of claims in order to ensure that all transactions occur within the program's guidelines and requirements. For each claim paid by HMSA, the computer system must verify the following:

- The person receiving the services is a Medicaid eligible recipient,
- The provider delivering the services has been properly authorized to do so,
- The services delivered have been properly authorized and are within the scope and limitations of the program,
- The reimbursement for services rendered is appropriate and within the guidelines of the program,
- The services have been appropriately delivered to the recipient, are medically necessary, and do not constitute a fraudulent or abusive act,
- The necessary reports are prepared for management information and control purposes.

These requirements for claims processing and information retrieval form the basis of a computer-based system which is known as the "Medicaid Management Information System" or MMIS.[1/]

In order to provide an incentive for states to develop and continually update their MMIS's with the necessary enhancements, the Federal government provides 90% of the cost of design, development, and installation of a conceptually approved system and certain system modifications. To receive the 90% reimbursement, the State or its fiscal intermediary must abide by DHEW's design guidelines. 2/

If a state's MMIS is approved, or certified by DHEW as meeting all Federal requirements, the Federal government pays 75% of the administrative expense associated with operating the system. 3/ A system not so approved can only obtain 50% reimbursement of the State's costs from the Federal government.

The automated claims processing system that HMSA operates on the State's behalf is a certified system approved by DHEW. Although it is generically a Medicaid Management Information System it contains minor variations from the model DHEW system. However, these differences are not critical and do not preclude the State from receiving maximum Federal reimbursement.

The system HMSA developed and currently operates for the State is one of 14 state systems to have an approved MMIS. 4/

Briefly, HMSA's version of the MMIS takes eligibility data (via the eligibility data tape received from DSSH), and other manually prepared data (such as data on new providers, the various types of provider claims, changes to provider's status, special report requests, etc.), processes this data, and prints out payment checks and remittance advices for providers, error reports, management and control reports, and special analysis reports.

The Hawaii MMIS consists of five integrated subsystems whose basic functions are to process Medicaid claims and provide management with the necessary reports to manage and control the program. Briefly, these subsystems include the following functions.

- Recipient Subsystem - Maintains the master file of eligible recipients and produces various reports on recipients.
- Provider Subsystem - Maintains the master file of all program providers and professional participants and produces various reports.
- Claims Processing Subsystem - Processes the claims submitted by checking against information in other subsystems, and performs, as a minimum, recipient eligibility verification, provider verification, rate or price verification, and duplicate payment cross-checking.
- Surveillance and Utilization Review Subsystem (SURS) - Aggregates claims processing information and generates integrated statistical profiles of utilization of services.
- Management and Administrative Reporting Subsystem (MARS) - Generates key reports of program operations and status.

To gain a thorough understanding of the claims processing system the consultants reviewed the available systems documentation and, where necessary, prepared flow charts of the systems operations. Interviews were conducted with individuals responsible for operating the system and observations were made of selected system functions. Additionally, the Hawaii claims processing system was compared with claims processing systems in other states as well as the requirements of the model Medicaid Management Information System. Specific emphasis was placed on evaluating the timeliness, usefulness, and effectiveness of the information produced for the Hawaii Medicaid program as well as on the accuracy and completeness of the claims processing function.

A. PROCESSING ACTIVITIES RELATED TO THE RECIPIENT

Background

The principal functions involved in activities relating to the recipient include the following:

". Maintain identification of all recipients eligible for Medicaid.

. Provide the mechanism for frequent and timely updates to all recipient eligibility records.

. Exercise control over data pertaining to recipient eligibility, including Medicare Part B Buy-In Processing.

. Provide a computer file of all eligible recipients to support claims processing, review activities, and management reporting.[5]"

. Issue recipient identification cards.

The last function, the issuance of recipient identification cards, is a major responsibility of HMSA. The other functions are for all practical purposes accomplished by DSSH and provided by means of a complete and updated weekly tape to HMSA.

Another recipient-related activity is the forwarding to the recipient of an explanation of medical benefits received (EMB). This transmittal of information is required by federal medicaid regulations to be forwarded to a sample of recipients.[6]

Findings

Under the current arrangements between HMSA and DSSH, these functions except for issuance of I.D. cards are largely performed by the Case Information Computer System (CICS) in the DSSH Office of Information Services.

Each week, DSSH sends a computer generated tape to HMSA containing data on all eligible recipients. This tape is the recipient related file for HMSA's Hawaii Medicaid Management Information System. This complete file is then used to issue identification cards to eligible recipients on a monthly basis.

HMSA accepts the tape from DSSH as it does not have responsibility for any eligibility determination activities under the agreement with DSSH. Thus, the accuracy of the eligibility data received by HMSA on the tape is the responsibility of DSSH. HMSA does have certain automated reviews or edits built into its computer system to assure the completeness of the eligibility data transmitted by DSSH.

A problem occurs because a new recipient file is integrated into HMSA's system each week while the I.D. cards are distributed monthly. This means that oftentimes the information on the I.D. cards is different (older) than the information in the computer. Since providers rely on the information shown on the I.D. card for the preparation of claims, the recipient data on the claims may be different than the data in the computer recipient file. This can result in rejection of claims by the system.

Recipient Identification Cards. A review of the claims processing activities involving recipient I.D. cards reveals a number of problems. The numbering scheme used to identify recipients is overly complex, sufficient data are not provided on the I.D. card for providers, and certain I.D. cards are issued more frequently than necessary.

I.D. Numbering Scheme. The recipient identification number is a thirteen digit alpha-numeric code including an additional two digit code to identify each family member. The number of digits comprising the recipient identification number (thirteen) is excessive. Inasmuch as there are approximately 93,000 recipients, a seven digit code would be sufficient and still allow for expansion. The use of a thirteen digit number increases the probability of clerical errors

when claims are prepared. The use of fewer digits in the recipient identification number would reduce the likelihood of such errors.

The first digit in the identification number is an alphabetic code which specifices the public assistance category of the recipient (i.e. assistance to the aged in a "A" prefix, assistance to the blind is a "B" prefix, etc.). The prefix is changed when the recipient's public assistance category changes. This means the identification number changes. If a change in a recipient public assistance category is made during the month, or during an episode of illness which continues over the end of a month, the identification number in the Hawaii MMIS is different than the identification number on the recipient's identification card. Since the provider would normally not be aware of a change in a recipients' assistance category, claims are submittted under the "old" recipient number, i.e., the number on the recipients' identification card. Such claims are rejected and require additional effort by HMSA to identify the "new" recipient identification number and to resubmit the claims on behalf of the provider.

Sufficient Data Not Provided on I.D. Card. HMSA uses the computer tape received from DSSH to generate recipient identification cards. These cards are mailed to the recipient by HMSA. Exhibit 6.1 shows the form of the card currently used.

The identification card does not show the amount of cost sharing the client is required to assume for the services received from the program. Readily available cost sharing information on the identification card would allow providers to identify what cost sharing amounts they are to collect directly from the recipient. This would reduce the errors that arise from providers submitting claims for full payment from the program when a portion of the amount is to be paid by the recipient.

There is no physical description of the recipient(s) on the card. The lack of physical description, such as age, sex, height, weight, color of eyes, and color of hair, allows the cards to be easily loaned to person not eligible for program benefits.

Finally, the program has imposed certain limitations on the delivery of services to recipients. For example, a recipient is only entitled to one pair of glasses per year, unless otherwise authorized by the program. No information is currently available regarding any restrictions or use of services by a recipient on the identification card.

Periodic Distribution of I.D. Cards. Identification cards are issued monthly for all recipients. Yet, the status of some recipients, such as the aged, permanently and/or totally disabled, and the blind, is not subject to frequent change.

Control of Explanations of Medical Benefits. The stated purpose of generating the statement of Explanations of Medical Benefits (EMB) and mailing it to recipients who receive medical services is to provide a basis for the recipient to verify that the services are actually received. As required by federal regulations, EMB's are now generated within 45 days of payment and mailed to a sample of service recipients.7/ However, the EMB's are not adequately controlled after generation. No input or recipient responses to EMB's is included for accumulation, action, or followup. Thus, there are no data available to allow DSSH to follow up on complaints and discrepancies identified by recipients.

Recommendations

The recipient I.D. card serves numerous key functions. The card should inform the provider that the person is entitled to benefits within a certain Medicaid program, scope, and limitations. The provider assumes that the information on the card is

also the same as that used by the fiscal intermediary. Problems with I.D. cards, whether allowing for their use by unauthorized persons, receipt of services outside of program limitations, or not adequately identifying cost-sharing provisions, cause a breakdown in effective program control resulting in unnecessary expenditure of public funds.

Finally, problems associated with overly complex numbering procedures, or discrepencies between I.D. card number and recipient identification number contained in the computer system, lead to provider relations problems and excessive resubmission of rejected claims.

It is recommended that:

1. The recipient identification number be shortened and that the alphabetic prefix not be used as a control field, but retained for use in sorting and other statistical purposes.

2. The identification card be revised to include additional information. The card should provide certain physical descriptions, such as age, sex, color of eyes and hair and height to minimize unauthorized loaning of the card. It should also show any cost sharing requirements or benefit restrictions.

3. Aged, blind, and permanently and totally disabled clients, since their Medicaid status is unlikely to change on a month-to-month basis, receive a Medicaid card every six months concomitant with recertification.

4. A method be designed to provide for follow-up and investigation of discrepancies reported by recipients resulting from the EMB process. At a minimum, the supporting manual procedure should include preparation of a log of EMB inquiries. This log should be consistently maintained and final disposition of each and every inquiry indicated. Adherence to these procedures will assist in ensuring that recipients actually received the services for which a provider has billed the program, and thereby, serve as a deterrent to fraudulent and abusive practices.

B. SUBMISSION OF CLAIMS BY PROVIDERS

Background

The principal functions which are required once a claim is entered into the automated claims processing system include the following:

- All claims and related transactions are accurately entered into the computer system on a timely basis.
- There is a strict set of controls to ensure that all transactions are processed completely and promptly and that all discrepancies involving claims are resolved on a timely bases.
- The eligibility of both the recipient and the provider and the claim information is valid.
- Payment to providers is correct and made on a timely basis.
- There is a computer file of adjudicated claims to support review activities and management reporting.[8]
- Payment has been received by providers from sources with responsibility for providing payment for eligible recipients, such as: insurance companies, workmans compensation programs, etc. prior to billing Medicaid for any additional claim.

The early and periodic screening, diagnosis and treatment program (EPSDT) which is mandated for all eligible persons under 21 has special reporting requirements. After payment is made it is essential to develop a profile of examinations made and services rendered to these recipients. Since the EPSDT program provides services to a large number of recipients who are highly transient and use different providers, only reliance on computer techniques will suffice in providing management with the necessary reports. Recognizing these problems the Federal regulations require states to adhere to specific procedures in keeping track of these recipients and the services they receive.[9]

Findings

In the HMSA system, after furnishing services to recipients, each provider submits requests for payment to HMSA by means of a claim document. As discussed previously some claims require additional recipient information. Once the recipient information is complete all claims may require some manual processing to complete all service data, such as proper procedure coding, provider identification coding, drug pricing, etc. The information is then inputed into the automated claims processing system by HMSA clerical personnel. A number of processes take place depending on the specific type of claim. Generally, the steps that are involved include:

- Determine whether the provider is an eligible provider.
- Determine whether the recipient is on the most recent and complete recipient eligibility master file obtained from DSSH.
- Validate through use of internal computer program checks for completeness and consistency of data and that the claim is not a duplicate of a previously submitted claim.
- Identify claims where a portion of the claim should be paid by other than Medicaid, e.g., those claims for which "third party liability" exists.

Claims unable to pass the above validation steps are placed in a suspense file to await corrective action. The computer prepares exception listings for these claims in the suspense file. These reports are then forwarded to claims correction clerks and medical review personnel as indicated by the type of problem causing the claim to be placed in the suspense file. Claims which pass all of the validation routines are approved for payment and internally accumulated to be paid at the next payment cycle. At that time, payment instructions with the necessary supporting documentation are computer produced. For these paid claims, the data records are maintained for further use in review and reporting procedures. The final function of the claims processing activities

is to produce the federally required "explanation of medical benefits" form. This form is mailed to the recipient for whom the payments have been made.

A review of the claims processing activities as used by HMSA revealed problems related to the following areas.

1. The data on claims forms as submitted by providers.

2. The handling of claims where potential liability of either the recipient or of a third party exists.

Claim Forms Data. Claim forms are the vehicle by which the providers request payment for services rendered. Because there are widely different information requirements for each type of service rendered providers are allowed to use a variety of forms for requesting payment for services rendered. Many of these forms do not contain sufficient data fields upon which to obtain the information required to establish payment. In addition, the variety of claim forms results in slower processing because of increasing the review requirements and increased incidence of missing data. This is especially evident during the input of data to the computer because the input clerks must visually search the dissimilar forms for the data required for computer entry.

In reviewing provider claims for payment, it was noted that a high percentage of the claims were incomplete in that they had at least some missing data. The most prevalent omissions were for service codes. These are the codes which indicate the nature of the service rendered or item delivered to the recipient.

Claims processing personnel code the claim to reflect the procedure that is closest in their judgement to what is described on the claim. This results in most instances in the clerk making personal judgement decisions in selecting an appropriate procedure code.

In attempting to develop statistics on the degree of this problem, it was determined that no comprehensive procedure exists at HMSA to (1) determine the extent of the problem by individual provider, and (2) follow up and educate providers who continually miscode their claims or fail to submit all of the required data.

Providers who perform early and periodic screening, diagnosis, and treatment (EPSDT) services are currently permitted to submit claims on either the "Sceening Invoice" (HMSA Form #209) or on "HMSA and Title XIX Physicans Report of Services Rendered" (HMSA Form #9). The latter form does not contain data fields (such as diagnostic or referral information) that are required to report adequately and control EPSDT screening activities. Allowing the use of this form restricts the management data that must be available to control adequately this important service.

Cost-Sharing by Medically Needy Recipients and Third-Party Liability. Payment for a recipient's medical bills can occur in two basic ways: first, by the program and, second, by a source other than the program. These other sources include payments by the medically-needy recipients or payments by third parties such as insurance companies. The medically-needy have a requirement to share the cost of their medical expenses up to a monthly limit. This limit is a function of their net available resources, the basic subsistance level, and their medical expenses. For example when a medically-needy recipient has net available resources of $350 per month and the basic subsistance level is set at $300, the recipient will be required to share the cost of medical services up to the first $50 of incurred medical expenses per month. The program will pay the balance, if any.

The second way in which payment from another source is required is from a third party, i.e., someone other than the Medicaid program or the recipient. Third party liability (TPL) arises when the recipient is covered by some form of health or medical insurance. TPL can also result as a consequence of an accident involving a recipient, where another party is at fault and subsequently liable for the recipient's medical bills.

The current procedures to control cost sharing by recipients do not provide a mechanism to determine the amount spent by a recipient in a given month. Thus, there is no way HMSA can determine whether or not the recipient should be required to cost share on any specific claim.

HMSA is only able to enforce the cost-sharing provisions of the Hawaii program in those cases when the amount billed from one provider is large enough to require the total monthly cost-sharing amount to be offset against one claim. Hospital and nursing homes are the providers that normally generate larger claims. As a result procedures to collect the amounts due from recipients who are institutionalized have been established. For services rendered that do not involve an institutional stay there is no procedure for determining whether recipients paid their portion of the bill in those cases where they are required to share in the costs.

These deficiencies occur because the Hawaii MMIS does not have the capability to; (1) identify those recipients required to cost share, (2) identify the cost sharing amounts required, (3) accumulate the amounts paid by recipients to ensure that they have met their total liability, and (4) notify providers when additional amounts are due.

The Medicaid program is legally the "payor of last resort" as all third parties are suppose to pay for medical services for recipients to the full extent of their liability before Medicaid pays for any services. Any amount remaining unpaid after collection of insurance payments is then paid for by Medicaid. Undetected third party liability results directly in overpayments by the program.

Third party liability most commonly arises when recipients are covered by health or medical insurance such as from an employer's group plan. Employed recipients usually have some type of coverage[10/] while in some circumstances a recipient may have limited coverage for a specific illness such as cancer. Caseworkers are instructed to determine whether a recipient is covered by any form of insurance. The accuracy of the information obtained from recipients regarding insurance coverage is minimal at best, and currently there are no means available to DSSH to obtain this information from other sources.

Third party liability also occurs from settlements of claims as a result of automobile accidents. Under Hawaii's no-fault insurance law, no-fault benefits--including medical benefits--are paid up to a limit of $15,000. Up to 1977, the law specified that all no-fault benefits are to be paid secondarily and net of any benefits a person is entitled to receive from social security laws, workers' compensation laws, or public assistance laws.[11/] In 1977, Act 168 was passed to delete the requirement that no-fault benefits be paid secondarily and net of benefits from public assistance laws. This was done to insure that Hawaii would not be in conflict with federal regulations requiring that Medicaid not be a primary resource when other resources are legally available. Thus, where a Medicaid recipient requires medical services because of an automobile accident, recovery for medical expenses incurred must first be sought from no-fault insurance.

A problem that arises from time-to-time involves the recovery of Medicaid costs from a recipient who successfully sues for damages resulting from an accident. If the recipient refuses to assign the benefits from the suit to the State, there is no mechanism for recovering the amounts paid on behalf of the recipient. Because settlement is usually several years after the accident, the recipient may no longer be a resident of Hawaii or may no longer qualify for any form of public welfare. The only course of action available to the State is to deny further benefits to the recipient.

Accident cases are identified during claims processing and a computer generated report is prepared for DSSH. From that report, and the involved case records, DSSH determines whether cost recovery from another party is possible. Based on this information, an accounts receivable record is established in the Fiscal Office of DSSH to serve as the basis for follow-up as legal or other action proceeds. As of October 1977, over $168,000 was reflected on those records as being outstanding. 12/

DSSH lacks the procedures to determine readily the status of those cases where recovery potential exists. Prior review by DHEW have documented cases where potential recoveries have been lost due to a lack of follow-up by DSSH. 13/ This review indicates that the internal control over those cases continues to be insufficient to ensure that appropriate follow-up occurs on a timely basis.

HMSA's methodology for controlling and collecting TPL was evaluated. A sample of TPL transactions was traced through the HMSA system to determine whether the sample transations were processed correctly. No exceptions to appropriate action were found, and it appears that HMSA is properly processing TPL transactions.

The procedure HMSA uses for collecting TPL from providers who have submitted claims without TPL indicated is as follows. When the claims are current (i.e. just submitted and not processed), HMSA notifies the provider that the claim should be resubmitted with TPL deductions taken. When the claim has already been processed through the system for payment, then HMSA notifies the provider that should a remittance for the TPL amount not be received by HMSA within 30 days, that amount will be automatically deducted from the next Medicaid payment due the provider. If the request is not complied with, HMSA will deduct the TPL amount from the providers next claim payment, manually prepare a revised remittance advice showing the amount deducted, and send the revised remittance advice and the payment less the TPL amount to the provider.

Claims Processing Time Requirements. An important consideration is the time required to process a claim once received by HMSA. In the Hawaii MMIS the system compares the date the claim was received by HMSA to the date of payment. HMSA's operational efficiency was reviewed by analyzing its capability to process submitted claims. The study indicated that for physicians 91.8% of claims submitted were paid within 30 days, 98.1% within 60 days and 99.3% within 90 days as shown in Exhibit 6.2. The exhibit also shows the payment periods for other provider categories. Although HMSA appears to be paying claims on a timely basis, they are not in strict compliance with the terms of the contract which states that valid claims are to be paid within 20 days.[14/] According to their report of "Medicaid Claims Thruput Analysis" for August, September and October of 1977, only 79.7%, 79.1% and 81.6%, respectively, for those months were paid within the allowable period of 20 days.

Recommendations

In order for the automated claims processing system to operate in an optimal manner it is essential that the inputting of data be effective, efficient and timely and undertaken at a minimum of

cost. Although this requirement seems simple enough, in actuality it is an extremely complicated, intricate, and difficult effort. There are literally thousands of procedures, services, drugs, supplies, etc. The proper assignment of a code identifying each one of these items may prove difficult because in many instances it requires a high degree of judgment by the provider. Furthermore, practitioners are not trained and often complain that they do not have the time or adquate resources to undertake the attention to detail that proper coding requires. However, before automated claims processing can be accomplished, the input information must be in proper codable form. At present this coding step appears to be a major problem at HMSA resulting in additional cost burdens and processing delays.

Timely processing of claims is critical to good provider relations. Long processing time usually indicates internal problems, whether caused by the fiscal intermediary or resulting from difficulties in inputting and processing data. In either case these delays translate into increased costs and strained and unpleasant relationship with providers. In Hawaii, neither of these appear to be of significant consequence especially when one compares current activities with other Medicaid programs. 15/

The federal government has stipulated that sanctions will be imposed upon finding the AFDC program for inadequaces in the EPSDT information tracking system. 16/ Thus, it is imperative both from an internal program basis as well as a compliance requirement to have an EPSDT tracking system.

Proper fiscal management of the Medicaid program as well as compliance with state and federal regulations require that all cost-sharing for the medically needy and third-party liability be determined and collected. Monies obtained from these sources remove an additional burden on the funding of the State Medicaid program.

It is recommended that:

1. HMSA standardize the claims form to the maximum extent possible with adequate provision for a full and optimal description of services provided.

2. Providers be required to fill out their claims forms completely and accurately prior to submission. Those forms that are not complete, when errors exceed a pre-set criteria list, should be returned to the provider for completion. In addition, provider training in preparing claims should be made a major educational effort of HMSA.

3. The claims screening process include a provision for identifying those providers that chronically submit incomplete and/or inaccurate claims so that appropriate followup action such as training or sanctions can be taken to correct the situation.

4. Early and periodic screening, diagnosis and treatment practitioners in order to receive reimbursement be required to submit the authorized "Screening Invoice" form. In this manner the program can capture all necessary EPSDT information.

5. The Hawaii MMIS be modified to identify properly and account for the medically-needy recipients' cost-sharing responsibilities.

6. With respect to improving the identification of cases where potential third-party liability exists, DSSH procedures (a) to cross-check the Department of Labor's files to determine whether there are recipients currently holding jobs that they have not reported, (b) to determine whether or not recipients who are employed are covered by some form of health or medical insurance, and (c) to determine in cases of no-fault insurance claims whether a Medicaid recipient is involved.

7. Assignment of benefit statement which is currently obtained only when a case goes into litigation be obtained from all Medicaid recipients during the eligibility determination process as a requirement of being covered by the program. This latter recommendation could be best accomplished by including a standard assignment of benefit statement on the application form that the recipient signs.

8. The method of collecting TPL amounts directly from providers by HMSA be automated and shown as a deduction on the provider's remittance advice produced by the Hawaii MMIS system.

C. PRIOR AUTHORIZATION

Background

The state program requires that for certain types of services and procedures prior authorization must be obtained from Medicaid program medical consultants in order for the provider to obtain reimbursement for services rendered to eligible persons. This approval, according to program directives, is not only mandatory, but must be obtained prior to the actual delivery of services.[17/] Exhibit 6.3 lists the services requiring prior authorization. Until September 1977, this function was performed entirely by MCAS utilizing its medical consultants. MCAS employs two full-time physicians and numerous part time professionals who provide the approvals for this process. Since September of 1977, this approval function has been transferred to HMSA for the majority of routine requests for authorization. In complicated or problematic circumstances MCAS physicians and consultants review the case.

Since there are a large number of items requiring prior authorization, the procedures for obtaining such approval must be efficient and timely so that the requesting provider receives the

necessary approval without undue delay and with a minimum of administrative interference. In order for prior authorization to operate in a manner consistent with its intent to control provision of unnecessary services, prior authorization must in fact be requested and approved in advance of rendering services. For the process to act truly as a control system, providers cannot be of the opinion that authorization can be obtained easily and routinely at any time, especially after services are rendered. Thus it can be readily appreciated that with numerous prior authorization approvals required, large numbers of requests daily, and voluminous claims submitted for payment for which prior authorization was required, a well conceived computer system must be relied upon. Only an automated component of the claims processing system can effectively match prior authorized services to subsequent related claims for payment for those services. Otherwise, given the massive claims workload, it is difficult, if not impossible, to ensure that only claims with valid prior authorization approvals receive payment when indicated. Finally, the system will ensure that arbitrary and capricious prior authorization approvals are not rendered after services are delivered.

Findings

To test the effectiveness of the prior authorization process, a sample of paid claims was reviewed to determine the existence and timeliness of the required approvals. Of 31 claims reviewed from skilled nursing and intermediate care facilities, six claims, or approximately 19%, had been authorized after the services were initiated. Of 14 dental claims reviewed that required prior authorization prior to being eligible for payment, none had been appropriately authorized, yet all were paid. Of 12 laboratory and x-ray claims reviewed, none had received authorization, but all were paid.

A review of MCAS logs showed that only 29 requests of 6,152 submitted were denied. It is not possible without a detailed medical review of each case to determine whether this 1/2 of 1% denial rate represents ineffective review or a high degree of compliance by the submitting providers.

The review of the prior authorization procedures indicated a lack of consistency in program documentation as to the authorization criteria. For example, Attachment 3.1A of the State plan specifies that laboratory and x-ray procedures anticipated to cost more than $25 require prior authorization. HMSA documentation for prior authorization does not make mention of this criteria and a number of system clerks were unaware of this requirement.

The automated claims processing system does not contain a prior authorization component.

Recommendations

A prior authorization system component should be available to review a submitted claim to determine whether the services rendered required prior authorization. If prior authorization were required, the system should check a prior authorization file to determine the following: (1) the authorization is on file, (2) the date of authorization is prior to the date of service, (3) the procedures rendered are the same as the procedures authorized, and (4) the charge for the services rendered are within the authorized limits, where applicable.

It is recommended that:

1. A computerized file of approved authorizations for which claims have not been submitted should be accessible to both DSSH and HMSA personnel via video display devices or terminals for control and inquiry purposes.

2. DSSH with the assistance of HMSA should review current prior authorization criteria for adequacy and ensure consistency in all program documentation and claims processing procedures.

3. DSSH should establish a review and appeals procedure and the required tracking mechanism, with full authority vested in MCAS, to handle disposition of claims for which proper prior authorization has not been obtained. This would include cases when authorization is obtained after the delivery of services or for submission of claims for services rendered when no approval was sought, although the service was proper and required.

D. MANUAL CLAIMS PROCESSING

Background

An important purpose of an automated claims processing system is to minimize reliance upon manual procedures and intervention. This is done in order to provide timely processing of claims, minimize cost, and control clerical errors. These factors are most important during the initial phases of claims processing. This is especially true for Medicaid because of the vast numbers of claims received, information processing requirements, potential errors on the claims, and the voluminous and analytic data required as reference to control the system. Poorly designed and operating initial claims processing procedures can hamper the viability of the total systems effectiveness and efficiency.

Findings

Claims forms are submitted to HMSA by the providers at the rate of approximately 6,000 per day.[18/] The initial step in the processing is the procedures followed in the HMSA mailroom. Mail related to the Medicaid program is received in a mailroom where it

is manually opened and sorted by type of provider or practitioner (i.e., physician, hospital, dentist, etc.). Mail is placed in cardboard boxes until stamped manually with the date received. After being opened, provider claims are assigned a control number by the mailroom clerks and manually stamped with that number. Claims are then transported to another location where they are microfilmed as a separate activity and then forwarded to claim processing personnel.

Each claim is then coded with the date and a control number. If the claim: (1) is incomplete, (2) involves another payor (the so-called "third party liability" cases), (3) indicates potential Medicare coverage, (4) indicates that cost sharing by the recipient is required, or (5) is for a newborn infant who does not yet have a recipient identification number, it is segregated for manual processing. Approximately 25% of the claims or 1,200-1,500 claims per day require manual processing.

To undertake manual processing, the clerk first must obtain any available information about the recipient from a record which is stored in the computer. The clerk then manually verifies the record for completeness and accuracy. The next step requires the manual coding of any recipient related missing data, such as: Medicare eligibility status, new born information, other insurance, etc. After the data are manually verified, and/or additional or corrected data entered onto the claim form, the claim is sent on for entry into the automated claims processing system.

Currently, there are approximately 18 people involved in this manual claims processing procedure. There is an absence of standardized claims review procedures for HMSA claims processing personnel to follow during this manual phase. These personnel have developed their own individual manual processing procedures.

Recommendations

To operate the claims processing system effectively and efficiently, manual operations should be reduced to a minimum. Additionally, mailroom procedures should ensure the utmost control over incoming claims in order to reduce the risk of loss or inappropriate distribution. Finally, it is imperative that standardized and well documented procedures be followed by all clerical personnel handling claims from receipt in the mailroom until input of data to the automated processing system.

It is recommended that:

1. Procedures should be instituted to obtain immediate and continual control over all incoming mail and claims prior to distribution. This should be accomplished by development of appropriate logging procedures. Furthermore, the microfilming and coding equipment should be located at the point of claims receipt (i.e., mailroom) to ensure immediate documentation and minimize possible loss resulting from a transfer of claims to a separate location.

2. HMSA should analyze current initial processing procedures in an attempt to lessen the reliance on manual procedures during the initial phases of claims processing.

3. The procedures for claims processing clerks should be standardized. These procedures must be documented to ensure that the clerks are performing only essential claims review steps and that they are performing these steps consistently and in a manner intended by HMSA and MCAS. Standard procedure manuals should be developed and training programs established to ensure understanding of the procedures.

E. CONFIDENTIALITY OF INFORMATION

Background

The program is required to comply with various confidentiality requirements established by federal law and regulation. These confidentiality requirements relate to the disclosure of information about recipients who participate in the Medicaid program. Specifically, the law states that the state agency will "provide safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with administration of the plan." 19/

According to the federal regulations, such purposes include: establishing eligibility, determining the amount of assistance, and providing services for applicants and recipients. Under these regulations, the types of information to be safeguarded include: the names and addresses of applicants and the amount of assistance provided, information related to the social and economic conditions or circumstances of a particular individual, agency evaluation of information about a particular individual, and medical data, including diagnosis and past history of disease or disability, concerning a particular individual. 20/

Findings

During our study, it was observed that HMSA provides minimal control over computer-prepared reports containing confidential information. One such observation revealed that old or unused reports containing confidential information are merely discarded rather than being destroyed or otherwise obliterated. Access to reports is only minimally controlled. However, computer terminals and access to programs appear well guarded.

Recommendation

Federal law, the courts, and public opinion have been uniform in their desire to protect the rights of all citizens. Public assistance recipients are no less entitled to protection. Because of the important nature of protection of confidentiality, adequate procedures in this regard must be established and maintained.

It is recommended that:

1. HMSA establish procedures to assure that all reports, documents, and other data on which recipient information is shown be appropriately safeguarded, destroyed or otherwise obliterated.

2. Procedures which ensure that confidentiality is safeguarded be thoroughly documented and periodically reviewed for appropriateness and adequacy.

3. Periodic audits be performed by MCAS to determine whether the safeguarding procedures are being appropriately followed by HMSA.

EXHIBIT 6.1

MEDICAID IDENTIFICATION CARD

Front

IF FOUND - PLEASE RETURN TO:

HAWAII MEDICAL SERVICE ASSOCIATION

P.O. BOX 860 • HONOLULU, HAWAII 96808

IMPORTANT: PRESENT THIS CARD WHEN YOU OR ANY ELIGIBLE MEMBER OF THE FAMILY GOES TO ANY PROVIDER OF MEDICAL SERVICES. IF YOU DO NOT TAKE THIS CARD WITH YOU THE PROGRAM WILL NOT BE RESPONSIBLE FOR PAYMENT OR SUPPLEMENTARY PAYMENT FOR YOUR MEDICAL SERVICES.

ASSIGNMENT: IF I AM ENTITLED TO MEDICARE BENEFITS, I ASSIGN SUCH BENEFITS TO THE PROVIDER OF SERVICES.

CAUTION: DO NOT USE THIS CARD WHEN YOU ARE NO LONGER ELIGIBLE FOR BENEFITS UNDER THE PROGRAM.

AUTHORIZATION: I AUTHORIZE ANY PROVIDER TO RELEASE MEDICAL INFORMATION TO THE DEPARTMENT OF SOCIAL SERVICES AND HOUSING OR ITS AUTHORIZED REPRESENTATIVE.

John Doe

SIGNATURE

(CARD NOT VALID UNTIL SIGNED)

Back

FAMILY CODE	ELIGIBLE PERSONS	
01	DOE, JOHN	Y
02	DOE, JANE	Y
03	DOE, MARY	Y
04	DOE, TIM	Y
05	DOE, LYNN	Y

HMSA IDENTIFICATION CARD

IDENTIFICATION NO	GROUP NO	CONC	COV CODE	EFF DATE
C021234501-9	40	3	90	10/01/74

JOHN DOE 26
P. O. BOX 600
HONOLULU, HI 96808

HMSA
R1090038-9/04,D,P,V 2/03/76

EXPIRATION DATE

Exhibit 6.1 A Medicaid Identification Card. See text for explanation.

EXHIBIT 6.2

TIME REQUIRED FOR HMSA TO PAY CLAIMS

SERVICE	PERCENT OF CLAIMS PAID WITHIN INDICATED PERIODS								
	AUGUST 1977			SEPTEMBER 1977			OCTOBER 1977		
	30 Days	60 Days	90 Days	30 Days	60 Days	90 Days	30 Days	60 Days	90 Days
PHYSICIANS' SERVICES	91.8	98.1	99.3	89.0	97.3	99.0	90.2	97.0	98.8
PRESCRIBED DRUGS	93.2	98.8	99.7	93.4	98.7	99.6	93.4	98.6	99.5
DENTAL SERVICES	83.8	91.4	94.3	78.9	90.0	94.1	81.3	90.1	94.1
INPATIENT HOSPITAL	93.4	99.1	99.6	91.3	99.0	99.9	93.0	99.1	99.7
OUTPATIENT HOSPITAL	95.4	99.3	99.7	93.9	98.9	99.5	95.9	98.9	99.5
NURSING HOMES	97.2	99.7	99.9	97.5	99.4	99.9	98.0	99.7	99.8
HOME HEALTH	98.5	100.0	100.0	99.3	100.0	100.0	99.3	99.3	100.0
INTERMEDIATE NURSING CARE SERVICES	99.2	100.0	100.0	99.3	99.6	100.0	99.4	100.0	100.0
EARLY PERIODIC SCREENING (EPSDT)	88.2	98.6	99.3	75.0	98.6	100.0	71.2	96.2	99.2
OTHER PRACTIONERS	89.1	96.4	98.4	82.9	93.7	96.8	77.2	93.7	98.6
LAB AND X-RAY	88.7	97.7	99.1	88.7	97.8	99.0	90.0	97.5	99.0
FAMILY PLANNING	90.7	97.4	98.9	85.7	97.1	98.8	86.7	94.5	96.7
OTHER SERVICES	90.1	98.8	99.6	88.5	96.9	98.7	86.3	97.0	99.1
TOTAL	91.9	98.1	99.2	90.3	97.6	99.0	91.2	97.4	98.9

Exhibit 6.2: Indicates the cumulative percentage of claims paid within the indicated periods of time.

Source: HMSA report number MR-10, Medicaid claims processing.

Exhibit 6.2

EXHIBIT 6.3

SERVICES AND PROCEDURES REQUIRING PRIOR AUTHORIZATION

- Acne surgery
- Benign skin lesions
- Hair transplants and miscellaneous skin procedures
- Destructive benign skin lesions
- As above plus expilation by electrolysis
- Mammoplastics
- Acupuncture
- Bone and cartilage plastic grafts
- Benign tumors of ribs, sternotomy
- Vertebral resection of "missing" spines
- Repair fixed deformities of the spine
- Abdominal fascial repairs
- Secondary repair, extensor tendons of hand
- Positional change of fingers
- Denervation of hip joint
- Hip arthroplastics
- Excision certain nasal lesions
- Nasal repairs
- Cardiac transplants
- Dental surgery
- Tonsillectomy
- Excision tonsillar tags
- Esophagoscopy with insertion of radioactive substances
- Total hepatectomy with transplants
- Hernias other than inguinal
- Renal transplantation
- Cystourethroscopy with insertion of radioactive substance
- Circumcisions after 1 year of age
- Plastic penile procedure with insertion of prosthesis
- Insertion of testicular prosthesis
- Vasectomy
- Transection, fallopian tubes; same, post partum
- Same, by laparoscopy
- Salpingectomy, uni or bilateral
- Salpingoplasty
- Lobotomy
- Eye muscle procedures
- Ear piercing
- Transportation of x-ray equipment
- Radiotherapy and nuclear medicine
- Autopsy and whole organ studies
- Neuro-psychiatric services
- Orthoptic training
- Auditory training/speech reading, training
- Speech and language evaluation
- Echograms
- Airline transportation
- Supplies

Exhibit 6.3 A list of services and procedures requiring prior authorization. See text for explanation.

Source: Medicaid Provider Manual, HMSA, February 1976,

Exhibit 6.3

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1/ MMIS: General Design for Title XIX, Office of Information Systems, Social and Rehabilitative Services, Department of Health, Education and Welfare, December 1973.

2/ 45 CFR 250.90, Federal financial participation: Mechanized claims processing and information retrieval systems; or CCH, pp. 8513-8515.

3/ Ibid., p. 8515.

4/ Personal communication between Arthur Young and Company and DHEW.

5/ Op. cit., "MMIS," p. I-11.

6/ 45 CFR 250.90(b)(2)(v), Federal financial participation: Mechanized claims processing and information retrieval systems.

7/ Ibid.

8/ Op. cit., "MMIS," p. I-11.

9/ 45 CFR 205.146(c), Penalty for failure to provide early and periodic screening, diagnosis and treatment of children under Title XIX of the Act; or CCH, pp. 8571 through 8572.

10/ Hawaii's Prepaid Insurance Law, Act 197, SLH 1974, requires every employer with more than five employees to provide health insurance for all employees who work more than 20 hours per week.

11/ HRS, Chapter 294.

12/ Monthly Report of Benefit Payment Transactions, Fiscal Office, DSSH, October 1977.

13/ Report on Audit of Medical Assistance Program, Title XIX, Social Security Act, State of Hawaii, DHEW, December 1976, Audit Control No. 70208-09, pp. 23-36.

14/ HMSA contract, p. 9.

15/ "What We've Learned from the Medicaid Mess," American Medical News, October 25, 1976.

16/ Ibid., "Penalty for failure to provide screening"; or CCH, pp. 8571-8572.

17/ CCH, pp. 6403-2 and 6403-5 through 6406.

18/ HMSA report of per day claims volume.

19/ Social Security Act, Section 1902(a)(7); or CCH, p. 7202.

20/ 45 CFR 205.50, Safeguarding information for the financial assistance and social services programs.

CHAPTER 7. THE RELATIONSHIPS BETWEEN PROVIDERS OF MEDICAID SERVICES AND THE STATE MEDICAID PROGRAM

An extremely important aspect of administering claims processing for the Medicaid program is the maintenance of relations with providers of services. A strong provider relations program is conducive to optimal program operations. The maintenance of good provider relations encompasses activities relating to proper and timely payment of claims, adequate instructions for providers in regard to use of the forms for reimbursement, prompt and courteous response to inquiries about the status of claims, and payment of an appropriate and reasonable reimbursement rate to providers for services rendered. Fulfillment of these activities in an optimal manner can assist in ensuring an adequate rate of participation in the program by providers. Good relationships will also tend to minimize the time spent resolving misunderstandings about program procedures as well as diminish processing errors resulting from the submission of erroneous and carelessly prepared claims forms by providers.

Interviews were conducted with administrative and financial management personnel in six insitutions (hospitals and nursing homes) regarding, (1) the nature of their working relationships with both DSSH and HMSA, (2) the nature of any problems they are experiencing with either DSSH and HMSA, (3) whether claims had been denied for payment and the circumstances of such denials, (4) the nature and impact of the program's review procedures of their institution, and (5) their impressions of the program's payment practices.

Provider manuals, instruction letters, and other procedural related material were reviewed. Additionally, correspondence with the providers was examined to determine the types of procedural and policy problems occurring between the providers and HMSA and DSSH.

The study disclosed issues requiring review in the following areas: (1) the consistency of the documentation given to providers as guidance for complying with program policy and procedures, (2) the adequacy of current payment procedures used by the fiscal intermediary and (3) the reasonableness of provider reimbursement rates.

A. MANUALS, BULLETINS, INSTRUCTIONAL MATERIALS, AND FORMS

Findings

In reviewing and receiving comments from providers in regard to the provider manuals and provider bulletins a number of concerns were identified.

The information in the provider manuals does not correspond in many areas with the policies and requirements of the State Plan. The prior authorization requirements as found in the State Plan are significantly different from those given in the provider manual. For example, the State Plan requires prior authorization for all dental procedures exceeding $50. However, the provider manual does not mention or explain this crucial requirement.

Provider bulletins are designed and issued in a fashion that is not conducive to easy incorporation into the provider manual. For example, provider bulletins do not have appropriate page numbers or titles. Therefore, they cannot be easily placed in the appropriate section of the provider manual when received by providers. Additionally, instructions do not accompany the bulletins to indicate the reason for the revision or additions. Also lacking is instruction on the procedure to be followed for inserting the bulletin into the proper place in the provider manual.

The provider manual was found to be incomplete. For example, the manual does not contain a step-by-step approach for preparation of many of the claims forms, prior authorization forms, and other program documents and/or forms required by the program. Where

instructions for forms completion were included in the provider manual or bulletin they lacked detailed and clear step-by-step procedures. Appropriate and useful lists of codes for items not found in standard coding manuals, but required for the Hawaii Medicaid program, are not included in the manual.

The cost sharing requirements and procedures for collection and reporting by the provider are inadequately described in the provider manual. Lack of instructions regarding this important and complex requirement can lead to incorrect collection and processing of provider cost sharing amounts. These problems and omissions lead directly to additional burdens for HMSA in the processing of claims involving cost sharing.

There is only one provider manual for use by all providers. Since the program interacts differently with various providers (hospitals, physicians, podiatrist, pharmacists, etc.), different instructional information is required to assist these various groups to meet their unique program needs. Specifically designed provider manuals is a need of the program because of the widely varying procedures and requirements that must be followed by each of the different providers. For example, the procedures which are followed in completing a hospital claim are significantly different than those followed in completing a pharmacy claim.

Under current procedures, the responsiblity to keep provider documentation up-to-date and complete is borne jointly by DSSH and HMSA, with HMSA carrying the major part of the burden. Yet, under the current contract the actual responsiblities vested in HMSA as agents for the State are not clearly delineated. As a result it appears that the responsibilites are shared equally leading to confusion and inconsistencies. There are no standard operating procedures to ensure consistency of information or for updating and completing provider manuals at either HMSA or DSSH. Instead of consistently applied program information procedures, HMSA and DSSH rely on the use of intermittent provider bulletins and instructional messages to transmit information to providers. As a result, instructions reach providers on a plethora of forms, stationery,

and other transmittal devices. Information transmitted in this manner no doubt leads to confusion, conflicting instructions, errors, and strained provider relations. Finally actions requiring the immediate attention of providers are not adequately highlighted.

Recommendations

It is essential to inform providers completely, properly and in a timely fashion about all information related to the Medicaid program. Anything less will result in confusion, conflict, errors, and delays by the providers which, in turn, leads to increased program costs and strained provider relationships. Well designed and carefully maintained provider instruction manuals, bulletins and other transmittal devices are absolutely vital to efficient program operations.

It is recommended that:

1. DSSH clearly delineate the responsibilities of HMSA in regard to developing, issuing and maintaining provider instructional materials as the agents for DSSH. In addition, the contract must specify the review and approval responsibilities retained by DSSH.

2. A complete revision of all provider instructional materials be undertaken immediately. The instruction material should as a minimum be developed in accordance with the following guidelines:

- Separate materials for each group of providers.
- Detailed and clearly written information regarding program requirements and operations.
- Detailed and complete information concerning scope and limitation of services by type of provider.
- Complete procedures to be followed regarding verificaiton of recipient eligibility.
- Detailed instructions for obtaining and procedures related to prior authorization and cost-sharing.

- Specific step-by-step instructions for completing reimbursement claims including detailed and extensive reliance on descriptions of the forms and detailed instructions for each space on the various forms.

- Clear instructions for requesting from HMSA information as to claims status or problems regarding payment.

- Necessary glossaries and list of non-standard codes used in completing claims forms.

3. A system of instructional material be developed which is easily used and maintained by the providers. Transmittal materials should be standardized into separate categories using unique forms which are designed to facilitate maintenance within a provider program manual. In this way instructions can be inserted into a standard manual while out of date and changed procedures are discarded. Also clear and concise information should be given as to the reason for changes and program modifications. Finally, providers should be able to obtain a complete manual when the providers have allowed their standard manual to become outdated and incomplete.

The system for instructional materials should include as a minimum the following types of transmittals.

- Provider alert notices -- those transmittals that require immediate attention or action.

- Provider Bulletins -- routine notices, information or policy changes affecting the provider.

- Provider manual revisions -- Program procedural and policy changes. Included should be an explanation of those changes and instructions for placement of the revisions in the manual.

B. DETERMINATION OF PROVIDER REIMBURSEMENT AMOUNTS AND RATES

Background

There are fundamental differences in the reimbursement methods available to the Medicaid program for payment of services rendered by professional practitioners as compared to institutional providers. Practitioners (physicians, dentists, optomertrists, etc.) can either be reimbursed on the basis of their usual and customary charges or on a fixed fee schedule determined by the Medicaid program. 1/ Institutional providers (hospitals, long term care facilites, and home health agencies) must be reimbursed on the basis of reasonable costs or charges, whichever is lower. 2/ Both groups are subject to the limitations that their reimbursement rates cannot exceed the rate reimbursed under the Medicare (Title XVIII) program. 3/ The fundamental difference between the methods is that the instutional provider is reimbursed on a cost basis while the professional practitioner is reimbursed without any direct regard to cost.

The selection of any reimbursement or payment system by the State, and the resulting rates that are paid to providers, is a matter of State public policy subject to federal law and regulations. There is no one universal methodology for setting rates that satisfies all involved parties. The providers want to receive what they consider to be fair compensation for their services while the Medicaid program and state officials have a public responsiblity to operate within budget and resource limitations.

It is essential to understand the guildelines for reimbursing practitioners and institutions.

Findings

Reimbursement for Professional Practitioners. The Hawaii program uses the usual and customary charges method for reimbursing physicians, dentists and other professional practitioners. The usual and customary charges method limits the payments the State can make to the provider according to a specific set of federal regulations. These requirements state that the reimbursement amount for a specific service or procedure is limited to the lowest amount determined by reference to the following amounts, (1) the actual charge, (2) the median charge of the practitioner during the previous 12 month period for all patients i.e. the usual charge, (3) the 75th percentile of charges by practitioners in the same specialty and geographic area i.e. the customary charge, or (4) the reasonable charge recognized in that area for the service and specialty under the Medicare program.4/

In Hawaii, the Medicaid program follows federal guidelines in reimbursing practitioners. HMSA maintains in its computer system detailed and up-to-date profiles on the charges submitted for Medicaid services rendered by professional practitioners. In addition, HMSA obtains the Medicare charge profiles from the Medicare Part B carrier in Hawaii, the Aetna Insurance Company, and uses these Medicare profiles for practitioners as a limiting constraint. This constraint serves to limit a Medicaid practitioner to no more than the reasonable amount as established under the Medicare program.

Thus, in Hawaii a practitioner should by regulation submit a charge based upon the practitioner's usual fee charged to all patients served. However, HMSA will reimburse the practitioner the amount submitted as the charge only when the amount does not exceed the lower of either the Medicare allowable rate, the practioner's

median charge for that service during the previous 12 months, or the 75th percentile representing the customary charge for that service in the community. Should the practitioner submit a bill for any amount below these limits, the amount submitted is paid.

In Hawaii, the majority of practitioners participate in the Medicaid program. Exhibit 7.1 shows the percentage of physicians and dentists participating during 1977.

One problem uncovered is that no action had been taken regarding practitioner reimbursement rates which must be updated every two years as required by Hawaii Medicaid law. 5/

Reimbursement for Institutional Providers. In Hawaii, institutional provider reimbursement rates are based on reasonable cost or charges, whichever is lower. For those institutions which are proprietary, federal regulations allow them to obtain, in addition to their costs, a fair return on their equity capital.6/ The rate of return is based upon a percentage equal to one and one half times the average of the rates of interest on special issues of public debt obligations issued to the Federal Hospital Insurance Trust Fund.7/

In many cases the charges for public hospital services in Hawaii are lower than costs for providing services. However, these institutions may still receive cost reimbursement because of an exception to the Medicare-Medicaid reimbursement regulations. This exception provides that payments to public hospitals providing services free or at a nominal charge shall be based on fair compensation for such services in accordance with the provisions of Title XVIII.8/ A provider's charges are considered nominal if the aggregate customary charges, or items represented by such charges, are less than one half of the reasonable cost of services.9/

The Medicaid program has established the following criteria to determine the reasonableness of institutional costs:

- Cost must reflect current costs of the individual provider. This precludes payment based on the cost of the services in some past period or based on a fixed negotiated rate for the services.

- Costs must be necessary and proper. Necessary and proper costs are costs which are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. They are usually costs which are common and accepted occurrence in the field of the provider's activity.

- Costs must be relatively consistent. The cost of providers' services vary from one provider to another and the variations generally reflect difference in scope of services and intensity of care. The provision for payment of reasonable cost of services was intended to meet the actual costs, however widely they may vary from one institution to another. This is subject to a limitation where a particular institution's costs are found to be substantially out of line with other institutions in the same area which are smiliar in size, scope of services, utilization, and other relevant factors.

- Costs must be related to care of beneficiaries. Reasonable cost includes all necessary and proper expenses incurred in rendering services, such as administrative costs, maintenance costs, and premium payments for employee health and pension plans. It includes both direct and indirect costs and normal standby costs. However, where the provider's operating costs include amounts not related to patient care, specifically not reimbursable under the program, or flowing from the provision of luxury items or services (that is, those items or services substantially in excess or more expensive than those generally considered necessary for the provision of needed health services), such amounts will not be allowable. The reaonable cost basis reimbursement contemplates that the providers of services would be reimbursed the actual cost of providing quality care however widely the actual cost may vary from provider to provider and from time to time for the same provider.10/

These guidelines are supplemented extensively by regulations further defining specific allowable costs and the accounting methods to be used in determining such costs. Thus, the current method of paying institutional providers is to reimburse them for the costs they incur in providing services to recipients.

To ascertain whether costs are reasonable and the institution has provided its cost report for reimbursement in a proper and accurate manner, the fiscal intermediary audits the providers cost reports from time to time. Since the institution has been submitting claims for payment for services rendered on a per patient basis, these audits are essential to establish the valid rates to be used by the institution. Periodically, the Medicaid program and the institution, based upon the audit findings, must make adjustments in the amounts reimbursed. This process, known as reconciliation, is performed annually and can result in payments either flowing from the State to the institution or vice versa.

Review of HMSA's procedures for rate determination and cost report auditing revealed that federal and state regulations and guidelines were being adequately followed with one minor exception.

Federal regulations require audits of provider's costs and the related settlement to be completed within a period of 2 years. During the review, it was noted that numerous provider settlements were not made within the allowable time period.

Recommendations

Rate and fee setting is one of the most critical concerns to both the state and the providers. Undoubtedly the level of reimbursement will remain an issue which can only be settled through compromise and negotiation among the involved parties.

What is important is that the method chosen is applied consistently, fairly, and with strict adherence to federal and state requirements. In this regard the study revealed that HMSA as the State's agent is undertaking this activity in a generally acceptable manner.

It is recommended that:

1. HMSA update the practitioner reimbursement rates according to State statute.

2. HMSA provide necessary staff and/or procedures to ensure that provider settlements are made within the allowable time periods.

C. FREQUENCY OF PAYMENT TO PROVIDERS

Findings

Providers, both institutional (hospital and nursing homes) and practitioners (physicians, dentists, etc), are currently paid by HMSA on a weekly basis. Approximately 1,200 checks are prepared every week. Funds for payment are transferred to HMSA from the Department of Accounting and General Services (DAGS). Currently, the remittance advice sent to the provider with the weekly check indicates the status of paid and unpaid claims. An explanation code on the remittance advice indicates the reason for rejection. The advice also notifies the providers regarding pending claims being reviewed.

Recommendations

The payment of claims is associated with numerous clerical activities, postage costs, computer operations costs, materials and handling expenses, and the development of timely and correct

remittance advices. All of these activities have an impact on program administrative costs that is proportional to the frequency of performing these activities. As such, frequency of payment should attempt to conform with the demands and needs of the providers while remaining cost efficient for the fiscal intermediary and the program.

It is recommended that:

HMSA change the payment cycle to no more frequently than once every two weeks.

EXHIBIT 7.1

PROFESSIONAL PROVIDER PARTICIPATION RATES, FISCAL YEAR 1977

Type of Provider	Number Available	Number Participating	% Participating
Physicians	1,299	1,198	(92.2%)
Dentists	580	481	(82.9%)
TOTAL	1,879	1,679	(89.4%)

Exhibit 7.1 The percent of physician and dental practitioners participating in the Medicaid program.

Source: Medicaid Report for the State of Hawaii - July 1, 1976 to June 30, 1977, HMSA, September 1, 1977, p. 18.

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1/ 45 CFR 250.30 (b)(3) Payments to individual practitioners; or CCH, P. 8506.

2/ 45 CFR 250.30 (b)(1), Inpatient hospital services; or CCH, P. 8505.

3/ 45 CFR 250.30 (b)(1), Inpatient hospital services or CCH, P. 8505; 45 CFR 250.30 (b)(3) Payments to individual practitioners, or CCH, P. 8506.

4/ 45 CFR 250.30 (b)(3) Payments to individual practitioners, or CCH, P. 8506.

5/ Act 150, SLH 1976.

6/ 42 CFR 405.429, Return on equity capital.

7/ 42 CFR 405.429 (a)(1), Principle; or CCH, P. 7891.

8/ 42 CFR 405.429, Reasonable charges; or CCH, P. 8505.

9/ Provider Reimbursement Manual - Part I, Article 2604.4; or CCH, P. 2564.

10/ 42 CFR 405.402, Cost reimbursement; general, or CCH, P. 7872; and 42 CFR 405.451, Cost related to patient care; or CCH 1977.

CHAPTER 8. PROGRAM ADMINISTRATION

This chapter focuses upon (1) the role of DSSH in administering the contract with HMSA, (2) the reasonableness of HMSA's charges for the services it provides to DSSH under the terms of the contract, and (3) the role and responsibility of DSSH and HMSA in program administration.

A significant portion of administration of the day-to-day program operations is carried out by HMSA as required by its contractual role with DSSH. However, ultimate responsibility for all program functions, including effective program administration, remains a legal and public responsibility of DSSH.

A. DSSH ADMINISTRATION OF THE CONTRACT

Findings

It appears as though DSSH has relegated most of the day-to-day administration of the program to HMSA. Control over most operational aspects of the Medicaid program have been shifted to HMSA to a major extent. It is now apparent that HMSA is, for all practical purposes, acting in more than an administrative capacity having assumed many management and policy making activities. As a result, DSSH has relegated itself to a mere caretaker of a few minor Medicaid functions rather than providing overall leadership, policy determination, planning, evaluation and program control. DSSH is not acting as the single responsible state agency for Medicaid.

DSSH has delegated additional functions for administration without defining how the functions should be performed, what additional allowable costs are involved, and how the contract should be modified to reflect the additional duties and responsibilities of HMSA.

As an example of the shift of control, many program and control functions are undertaken by HMSA consultants independently of DSSH. Interviews indicated that in almost all circumstances state policy is being interpreted and represented to providers by HMSA personnel with little or no DSSH presence.

A specific example is provided by an examination of the process by which changes are made to the Hawaii MMIS. It should be presumed that since the computer system is a predominant part of the state contract, modification to the system should be reviewed and approved by DSSH. DSSH should be involved in the process of developing specifications for any changes, obtaining time and cost estimates from the contractor, authorizing the planned work, monitoring the progress of the effort, testing and evaluating the changes, and formally in writing accepting the modified system. However, none of the above are currently being accomplished.

Recommendations

It is important to note that HMSA is not remiss in its duties under the terms of the contract, nor is it taking undue advantage of the situation. On the contrary, HMSA appears to be taking upon itself additional burdens to ensure effective Medicaid program administration. On the other hand, DSSH is utilizing HMSA to the fullest extent possible in order to administer the program on its behalf. DSSH has recognized that there are certain advantages and efficiencies in utilizing a third party, i.e. HMSA, to administer the program, thereby freeing DSSH from the numerous burdensome administrative requirements mandated within the public bureaucracy. The fault lies in the extent to which DSSH has overly delegated its public responsibility by allowing the managerial and policy making initative to reside in HMSA.

It is recommended that:

1. The initiative for administering the Medicaid program be assumed to a greater degree by DSSH through involvement in matters such as:

- Participating in all policy and managerial decisions
- Exercising greater control over all information system activities
- Involving DSSH personnel in all important provider related activities
- Participating to a greater extent in the application of program controls

2. DSSH assume a predominate role in Medicaid planning, budgeting, and research activities including the evaluation of methods and procedures installed by other Medicaid programs and the applicability for inclusion in Hawaii's program.

3. An immediate review of all administrative aspects of the relationship between the DSSH and HMSA be conducted and findings incorporated into a new contract.

B. DSSH FINANCIAL ADMINISTRATION OF THE CONTRACT

Findings

The study reviewed the financial administration by DSSH of the fiscal intermediary contract. Under the terms of the contract, HMSA is required to bill DSSH at cost for services rendered to the Medicaid program. Billings based on estimated costs are supposed to be rendered to DSSH on a monthly basis. The estimated monthly billings are based on a specified amount per claim. The claim is considered a work unit as defined in the contract. 1/ The costs incurred are to be separately identified in three areas.

- Routine claims administration and processing
- Audits of providers
- Special administrative work

For fiscal year 1976-1977 the maximum allowable charge per work unit for HMSA was not to exceed $1.07. DSSH was obligated to pay HMSA's costs but only to the extent that it did not exceed $1.07 per claim. The 1976-1977 HMSA cost per claim for routine claims processing and special administrative work for processing was $0.992. The cost for audit of providers was $86,572.28.

Since the monthly billings are based on an estimate of costs, DSSH makes a settlement with HMSA at the end of the fiscal year. This end of year reconciliation is based on a final accounting of HMSA's actual costs incurred in processing provider claims.

DSSH's fiscal administration of the contract is deficient on several counts. HMSA bills for routine claims processing activities by identifying the number of claims or "work units" processed, the estimated charge per work unit, and hence the total charge for routine claims processing as required by the contract. In processing the monthly bills from HMSA, DSSH does not verify that either the number of work units or the amount per work unit is appropriate. Therefore, DSSH is unable to attest to the reasonableness of the amount they approve for monthly payment to HMSA.

Further, DSSH permits HMSA to submit all charges, except those related to provider audits, as though they were part of the costs incurred for the routine processing of claims. As a result, DSSH is not informed about, nor can it exercise any control over, services related to the category of special administrative work. Special administrative work includes: special report preparation, unique or one time evaluations or studies, and other non-recurring requests or duties.

DSSH does not require HMSA to prepare a cost estimate for special administrative work prior to authorizing the work. HMSA however, does prepare gross cost estimates for internal purposes in most instances. Standard hourly billing rates for those HMSA employees who do the majority of the special administrative work have not been established in a manner useful for DSSH purposes of reimbursement. Therefore, a basis for providing budget estimates to DSSH does not exist.

Without a definite budget for the various tasks HMSA performs as special administrative work, there is no basis for DSSH to control the cost or approve the undertaking of such work. In effect, DSSH's current administrative practices allow HMSA to perform all special administrative work on an open ended cost basis without appropriate controls over the amounts the State will eventually pay for the work.

The lack of control over the costs HMSA incurs holds true for provider audits. DSSH does not require HMSA to prepare time and cost estimates for provider audits nor does DSSH impose any limits on the audit related cost HMSA can incur or approve the audits that HMSA will perform during a given period.

The most telling deficiency in DSSH'S administration of the contract is that DSSH has never performed a complete financial audit of HMSA's costs related to the contract. The year-end settlement with HMSA is based entirely on HMSA's statements which are accepted by DSSH without audit.

Recommendations

One of the most fundamental aspects of contract financial administration is the verification that the services billed for by a contractor have been received and that the billings are in accordance with the terms of the contract. In terms of the

DSSH/HMSA contract, this means that DSSH should verify that HMSA's monthly charges for administrative services are for services actually rendered and that the charges for routine claims processing are based on claims actually processed.

Since the contract calls for cost reimbursement, it is incumbent upon DSSH to audit HMSA's costs prior to the year-end reconciliation.

It is recommended that:

1. DSSH implement procedures for verifying the reasonableness of HMSA's monthly charges for routine claims administration and processing. As part of these procedures, DSSH should periodically verify the accuracy of HMSA's count of claims processed.

2. The cost of special administrative work and provider audits be billed separately as specified in the contract. The billings for such work should be based on standard hourly rates for the various categories of cost (such as personnel, computer time, materials, etc.). DSSH should require cost estimates from HMSA for special administrative work and provider audits and formally approve the work prior to commencement.

3. DSSH undertake a financial audit of HMSA costs each year. This audit should be undertaken by State audit personnel or by contract with a public accounting firm.

C. REASONABLENESS OF HMSA CONTRACT CHARGES

Background

This study was required to ascertain the reasonableness of HMSA's charges to the State. The study scope intended that a review of the reasonableness of the charges to the State be undertaken, but did not imply that a financial audit or an opinion be

rendered regarding HSMA's financial statements and internal cost reports. The review included:

- A review and documentation of the controls over the methods used to count claims paid and work units to ensure that the controls are reasonable.
- A review of the time spent on Medicaid activities by HMSA's employees.
- A review of payroll and fringe benefit records.
- A review of other direct costs for propriety of application to the Medicaid program.
- A review of indirect costs for propriety of amount and apportionment to the Medicaid program.
- A comparison of procedures and cost per claim with other fiscal agents.

The review disclosed that HMSA accumulates costs in the following general administrative expense categories:

Administration - These expenses represent HMSA administration of the Medicaid program as well as a portion of overall administrative support services for the entire organization.

Bill Preparation - This effort includes the daily receipt, review, eligibility verification, coding, and microfilming of claims, operating a telephone/walk-in claims service area for providers and recipients, the expense of forms, mailing identification cards and reports to recipients, and the coordination activity for all reports and special requests from the State and federal governments.

Utilization Review - This function consists of reviewing utilization data and compiling case records of potential fraud or abuse, summarizing and reporting to the State on such cases, as well as summarizing data relating to program utiliziation.

Financial and Statistical - This covers the responsibility for provider reimbursement and control; purchasing; payroll; accounting, review, control and summarization of management reports including special statistical information requested by the State.

Office Services - These services include the procurement, orientation and training of Medicaid employees; internal Medicaid printing; mail receipt and delivery, claim disbursement; and a delivery service between HMSA and appropriate State agencies.

Systems and Programming - Expenses for programming and system design for all computer functions such as the eligibility claims payment and reporting systems as well as special report request are included in this classification.

Data Preparation - This category of expenses includes the equipment and personnel needed to prepare and enter data into the computer system. Each claim processed requires the entry of data such as patient identification, provider numbers, service dates, diagnosis, types of procedures rendered, etc.

Computer Operations - Expenses for computer time used to process claims, prepare the Medicaid identification cards, prepare the report of benefits for recipients, run periodic management and utilization review reports, prepare provider checks, and prepare special request reports for State and federal governments. Costs for testing new program changes are also included in this category. 2/

Arthur Young & Company performed a limited scope review of the accumulation of costs in each of these categories and the subsequent cost allocation to the Medicaid program. The review consisted of an examination of such selected accounting records on a test basis as Arthur Young & Company considered necessary.

The procedures, however, were not extensive enough to constitute a financial audit of HMSA's records or reports in accordance with generally accepted auditing standards. Consequently, Arthur Young & Company does not express an opinion as to the reasonableness of any of HMSA's financial data contained in this report.

Findings

Nothing, other than those items noted below, came to our attention during our review to lead us to believe that amounts billed to DSSH for claims processing have been materially distorted,

in spite of DSSH's lack of review over HMSA's charges. Our review indicated that HMSA's charges to the State generally reflect the costs of the work performed for the Medicaid program insofar as our review could reasonably ascertain. Thus, in relation to the costs incurred by HMSA, the charges to DSSH appeared reasonable and in compliance with the contract requirement that HMSA bill DSSH only for the cost of services performed under the contract.

It was determined that five hundred hours were utilized for special administrative work and that no separate billing was made to DSSH for this time, as required by the contract. The costs for these services were absorbed in the routine claims processing charges.

Certain of HMSA's costs are allocated to the Medicaid program using methods which are not the most appropriate. The cost of the computer systems and programming personnel is allocated based on the amount of computer time required for the Hawaii Medicaid Management Information System and not on the actual time spent by these employees. On the other hand, an arbitrary 40% of the cost of the organizational unit responsibility for auditing providers and determining reimbursements rates is allocated to the Medicaid program.

The methods used to allocate HMSA's indirect costs to the program were examined. HMSA's indirect costs include: (1) the costs of those activities that are not directly related to Medicaid activities, and (2) costs which in part are related directly to Medicaid activities but for which only total costs are recorded by HMSA requiring allocation to the Medicaid program on some basis. For example, HMSA's internal cost systems do not segregate the time spent by systems related employees on Medicaid activities from other work. Instead, the total cost of this system function is allocated to the various HMSA insurance and other programs, including Medicaid, using as a basis of allocation the computer time

incurred by each separate program area. Thus, if 10% of the computer time was used for Medicaid claims processing, then 10% of the total costs would be allocated to the Medicaid program according to HMSA's procedures. Thus, HMSA's costs for those areas, in which direct allocations cannot be made, are allocated using as a basis the percent of total computer time utilized by Medicaid. However, it was found that Medicaid is not being allocated its calculated portion of costs. In the quarter ended June 30, 1977, only 14% of the electronic data processing department costs were allocated to Medicaid instead of approximatey 24% of cost which should have been allocated to Medicaid based on computer utilization time.

These allocation bases are inappropriate and appear to distort the cost charged to Medicaid. A cursory analysis was undertaken to ascertain whether use of other more appropriate allocation basis would materially affect the Medicaid cost. In each case, the estimated effect of changing allocation basis would not have been significant in relation to the amount DSSH payments to HMSA in 1976. However, circumstances could occur that would make such differences material. For example, the decision might be made not to further improve the Hawaii MMIS, yet under the current allocation method, a percent of the cost of HMSA's computer programmers and systems analysts would continue to be charged to the program. Conversely, if a major effort to improve the Hawaii MMIS were undertaken, HMSA may not be fully compensated for its costs under the current allocation procedures.

Recommendations

It is essential in the administration of any contract which is based upon cost reimbursement to have a well defined and appropriate means for calculating costs. The actual determination of

cost is not always a simple or straightforward exercise especially when the fiscal intermediary is responsible for administering numerous and widely varying programs.

The focal point of claims administration is the computer system. In addition, HMSA requires a large administrative support staff. The costs for the support staff, computer operations and overhead must be allocated to the Medicaid program in an appropriate and fair manner. Furthermore, DSSH must determine in advance how these costs are to be allocated in order to gain some measure of control and evaluation of expenditures. Finally, the State is required by federal guidelines (Federal Financial Management Circular FMC 74-4) to ascertain its processing costs because the federal government is providng a major (75%) portion of those costs.

It is recommended that:

1. DSSH institute cost finding requirements for the fiscal intermediary in conformance with federal guidelines and modify the contract to reflect these methods.

2. DSSH determine why HMSA has been charging less than full allocatable cost to Medicaid that is not consistent with HMSA's allocation procedures or terms of the contract.

CHAPTER EIGHT - FOOTNOTES

1/ HMSA Contract, Article V, Addendum 9, P. 56.

2/ Cost Expenditure Report, Title XIX Contract for Administration of Medical Assistance - Fiscal Year 1976-77, HMSA.

CHAPTER 9. MEDICAID PROGRAM CONTROLS

A. INTRODUCTION

This chapter focuses on the various controls that are available to or are a part of the Hawaii program. Controls mean those mechanisms that ensure that the activities of the program are being carried out effectively, efficiently, and within the scope, limitations, and regulations of the program. For the most part, these mechanisms focus on controlling the delivery of Medicaid services. When properly applied, these control mechanisms can lead to a containment of the rate of growth in overall program expenditures by ensuring that only necessary and appropriate program services are rendered to recipients.

For the Medicaid program to operate effectively and efficiently, it is necessary that services which are delivered be within the authorized scope of the program, be medically necessary and appropriate in relation to the recipient's health care needs, be of quality, and finally, be provided at a level of care which is the most economical and consistent with the recipient's medical care needs. This section briefly describes the nature and objectives of the various types of administrative controls that are available to the Medicaid program.

Prior Authorization. Prior authorization is the process by which services to be rendered to recipients are approved by a designated authority, usually a medical professional within the state agency, before the services are actually delivered. This is accomplished by having the provider describe the condition of the patient and the recommended procedures to correct the problem. The information is forwarded to the designated authority for review. The authority then reviews the case, approves or denies the requested treatment, and notifies the provider of the action taken.

While prior authorization can be required for all procedures and services, it is typically required for elective or optional services or those services which could be undertaken in a less expensive manner. In essence the state is requiring a second professional opinion regarding the medical desirability of a procedure through this process.

When the provider submits a claim for payment for a prior authorized service, a copy of the approved prior authorization form accompanies the claim. Before paying the claim, the claim is compared to the approved prior authorization to ensure that the services rendered were the same as the services authorized. If this is the case, and other portions of the claim are in order, the claim is paid. If not, the claim is rejected and returned to the provider unpaid.

Certification. Certification is the process of receiving approval in advance of rendering care stating that the care to be provided is medically necessary, at the appropriate level of care, and for a proper length of institutional stay. Procedurally, this is accomplished by having the physician provide a statement attesting to the medical necessity of the level of care contemplated and the length of stay required. This statement becomes a part of the recipient's medical record. Currently the requirement to certify the medical necessity of care is applied only to services provided by physicians in institutions (hospitals, nursing homes and home health agencies).

Review of Services. Medical care evaluations are intended to ensure that services rendered in a hospital are consistent with the provisions of appropriate services according to medical standards. They are retrospective (after the fact) reviews of care and medical practices in a hospital in order to assess the quality of care and utilization patterns for services and procedures rendered by the

physician. These are episodic, unique studies of the care given by a physician and are largely based on the analysis of aggregated treatment and diagnostic data. Thus, these studies focus on patterns of care as opposed to the review of individual cases.

Professional Standards Review Organization (PSRO). Since Medicaid was introduced, a number of program approaches have been developed to utilize the controls discussed above. Unfortunately, much overlapping and duplication of effort has resulted. In the following section a brief overview is presented which provides a description of a currently available control program and its potential use within the Hawaii Medicaid program.

The 1972 amendments to the Social Security Act required the states to establish procedures to review the utilization of the services provided as part of their Medicaid program. [1] The same amendment also established the Professional Standards Review Organization (PSRO) program to provide professional peer review for the Medicare program and the Medicaid program as well.

The 1972 legislation clearly establishes Congressional intent that the PSRO's will eventually provide the medical utilization review function to all of the states' Medicaid programs. [2] Fortunately, this intent was recognized early by DHEW and the separate regulations established for utilization review in Medicaid by the states are essentially the same as those for the review of Medicaid and other federal health care programs by the PSRO's. The state Medicaid program is therefore in a position to use the PSRO program to fulfill its utilization review requirements.

The PSRO program is based upon two underlying concepts. The first concept is that physicians should be responsible for reviewing the quality of care provided to the recipients of medical services. The second concept is that reviews by local medical professionals will provide the most effective and efficient means of utilization control.

Under the concept that utilization review is to be provided by local medical professionals, medical societies and other such organizations have formed nonprofit organizations for the purpose of carrying out the PSRO functions. Such organizations apply to DHEW for the assignment of PSRO functions over a given geographical area.

In Hawaii, the Pacific PSRO, Inc. is responsible for the PSRO functions in Hawaii, Guam, and American Samoa. Pacific PSRO, Inc. is conditionally designated by DHEW and it is currently fulfilling the utilization review requirements for Medicare patients in Hawaii's hospitals.

PSRO organizations are reviewed by the federal government and are granted "conditional" status when they are deemed capable of carrying out the basic PSRO review functions. After a trial period, which may not exceed 48 months, a PSRO can become "fully designated" and is then responsible for conducting all of the review requirements for all federal health care programs including Medicaid. The Secretary of DHEW has the authority to grant full designation status to a PSRO based on his evaluation of its ability to perform the review function. The law, however, requires the Secretary to consult with the single state agency in charge of the Medicaid program before doing so. In the event the state agency disagrees with the Secretary's decision to grant full designation, the Secretary must provide the state with an opportunity to submit additional evidence regarding the ability of the PSRO to perform its functions before rendering a final decision on full designation.

In carrying out their utilization review responsibilities, PSRO's utilize professionals from all health disciplines to review

care provided to both in-patients and out-patients. Out-patient review, however, is nominal at this time as the Federal law does not require development of ambulatory or out-patient care review procedures until October 1979.

Fully designated PSRO's must have active review functions that cover: (1) hospital based care and include admission certification, concurrent review, and medical care evaluation, and (2) long-term care. After October 1979, PSRO review must cover ambulatory care.

It should be noted that these review functions are required as part of a utilization review program for every Medicaid program even prior to the full designation of the local PSRO.

Hospital Reviews. Hospital review constitutes the principal activity of the current PSRO and Medicaid utilization review effort. PSRO's may either undertake the review in hospitals with their own staff or delegate the review function to the hospital utilization review committee comprised of its hospital staff. Before the utilization review functions can be delegated to a hospital, the PSRO must examine the hospital review system and procedures and determine that they meet or exceed the mandated PSRO review requirements. The State, for its part, must evaluate the activities of the hospital review committee but by definition must use its review services.

An important point about the PSRO program is that the PSRO must delegate the review function to any hospital that wants to do its own reviews as long as the established federal criteria are met. The PSRO must continue to monitor the review function in individual hospitals where it has been delegated. Thus, every hospital must meet the PSRO guidelines as well as those of the Medicaid program.

The cornerstone of the PSRO and medical utilization review programs in hospitals is concurrent review. This review must assure (1) the necessity of hospital admissions, (2) the appropriateness of the length of hospital stays and procedures to be rendered and (3) the effectiveness of hospital discharge plans. To make these determinations, the review program utilizes three types of review: admission review, continued stay review and the review of discharge plans.

- Admission Review. Admission review constitutes a pre-admission assessment of the medical necessity of an admission using diagnostic and procedural case standards or norms which are quite specific and pre-determined based on historical data. Once an admission is determined to be medically necessary, and initial length of approved stay is assigned using a local or regional length of stay norm for the diagnosis or procedure to be performed. Length-of-stay norms are statistically established for large numbers of patients of equivalent age and diagnosis.

- Continued Stay Review. Payment for care will terminate at the end of the assigned length of stay unless the attending physician requests an extension. Once the extension is granted, it becomes the determining factor in payment for care. More than one extension may be granted provided the appropriate requests are made.

  Two points are critical to understanding this portion of the PSRO program. First, the length of stay is only a guideline. Its assignment requires the physician to request an extension when the initial length of stay will be exceeded and have the extension approved by the program monitoring authority. This does not mean, as some have mistakenly complained, that the assignment of lengths of stay are an arbitrary limit on the amount of care a recipient can receive. Secondly, the patient, physician, and/or hospital may appeal any and all length of stay decisions via a predefined appeals procedure.

- Discharge Plans. Finally, hospital review includes a review of discharge plans, that is, a review of the disposition of the case to the appropriate level of care, such as, from acute inpatient care to a skilled nursing home (SNF), an intermediate care home (ICF), or the patient's home.

Long Term Care Reviews. PSRO's are also responsible for reviewing services provided in long term care (LTC) facilities (skilled nursing facilities and intermediate care facilities). The PSRO review process in LTC facilities is far less formalized than the review process for hospital based care. Much experimentation in LTC review is currently underway as this is a developing area of the PSRO program.

The objective of LTC reviews is two fold. First, it is to ensure that patients are receiving care in the appropriate level of care, i.e., that patients are in SNF's, ICF's or home care facilities consistent with their care needs.

Second, the review is to certify that the continued stay in the facility is medically necessary and the patient is receiving appropriate health, psychological and personal care. The review can also be performed as part of a periodic medical inspection of the facility. Medical reviews are delegated to health department personnel in many states.

Ambulatory Care Review. Ambulatory care review is the **most difficult review activity because of the wide variety of procedures rendered in the ambulatory care setting. As of today it is not being done extensively. It includes review of services provided in clinics, physician offices, and hospital out-patient facilities. At present, a number of demonstration sites are developing various techniques and procedures for establishing ambulatory care review. It is required by law that PSRO's develop a plan to provide ambulatory care reviews for all of the federal health care programs, including Medicaid, by 1979.**

The cost of PSRO reviews is borne almost totally by the federal government. Since 1975, the financing of PSRO hospital review has been provided directly from Medicare Trust Funds. The costs for management of the PSRO's are also funded directly from federal appropriations.

The point that needs to be emphasized here is that the State can obtain this vital management control function at very little, if any, cost by utilizing and "piggy-backing" its Medicaid review functions on the PSRO operations as allowed by federal regulations. Use of a PSRO to perform the utilization review function for the Medicaid program does not mean that a state gives up control over the review function. The federal government has insisted that the states be involved in all stages of PSRO and utilization control implementation. This is in recognition that states are responsible for a major portion of the financial support of the Medicaid program and must retain a key role in monitoring all activities regarding PSRO determinations on state expenditures, the quality of care, and appeals and complaints of program participants.

States maintain their involvement because PSRO's must request conditional designation from the federal government to take over all or some portion of a state's review function, and the federal government must consult with the states prior to awarding designation. The issue is whether the states are willing to subject one of their functions to an outside institution while retaining the crucial monitoring activity or whether more expensive state programs will be continued. Many states that perform the utilization review function themselves are realizing that the national PSRO program offers federal financial support and use of the organized and involved medical community.

It appears that the question is not whether the states will be required to delegate the responsibility for utilization review to the PSRO's, but when the delegation will be mandated by the Federal government. A recent settlement of a dispute regarding the involvement of the PSRO in the New York Medicaid program is a first step in the direction of mandating direct involvement of PSRO's in all state Medicaid programs.

The State of New York contended that their utilization review program was more cost effective than that of the PSRO, and there-

fore should be permitted to continue to perform the utilization review function for the Medicaid program. The state finally conceded that DHEW had the authority to require the PSRO to perform the utilization review function for the New York Medicaid program in spite of the state's desire to continue its own utilization control effort. [3]/

Each PSRO is required to develop administrative procedures for correlating its activities with those of the state in which it is located. These arrangements are to be incorporated into a "memorandum of understanding" between the state and the PSRO. A critical element in this agreement is the clear definition of the monitoring role of the state. The Secretary of DHEW is required to seek the state's opinion that the PSRO is equipped to perform its review before PSRO's status can be changed from "conditional" to "fully designated."

The assumption of the utilization review function by the PSRO does not preclude a state role in controlling Medicaid utilization. States are encouraged to monitor the performance of the PSRO through the data contained in the Medicaid Management Information System and by participating in on-site facility reviews. Thus the state has access to much of the same data as does the PSRO and can monitor utilization patterns on a sample basis whenever desired.

The regulations provide recourse to DHEW by the state in the event it feels that the PSRO is (1) adversely affecting the quality of the care provided Medicaid recipients or (2) increasing state expenditures for Medicaid services.

Two information systems support the utilization review and control programs. The PSRO information system is specifically designed to support its ongoing review functions. The Medicaid Management Information System is designed in part to support the State's utilization review activities and is operated by either the State or the fiscal intermediary.

B. UTILIZATION REVIEW CONTROLS

Background

In this section the controls over the utilization of services paid for by the State's Medicaid program are reviewed. The system for controlling the utilization of Medicaid services in Hawaii differs in some of its applications from the available control mechanisms described in the introductory overview of utilization control programs.

To ensure that the utilization controls described in various Hawaii Medicaid program documents were effective, a number of test procedures were designed and undertaken. A description of these tests, where pertinent, accompanies the test findings. Based upon the findings, the existing federal requirements, and experiences in other states, rcommendations for correcting the deficiencies or improving the current control mechanisms are provided.

Findings

Hospital Reviews. The Hawaii Medicaid program does not make use of the medical review services of the PSRO in the State. The Hawaii PSRO, Pacific PSRO, Inc., was conditionally designated by DHEW in July 1977 to perform the hospital utilization review function for the Medicare program in Hawaii and it is currently performing the function.

DSSH relies upon the federal and state utilization review requirements which mandate hospitals to form their own review committees. These committees develop utilization review procedures that are identical, for all practical purposes, with PSRO procedures. The differences that do exist relate to the interrelationship of the review function between Medicare and Medicaid and the PSRO data collection procedures.

The existing arrangement is inefficient and questionable. DSSH's insistence on operating a separate review system causes duplication of effort in the hospitals and unnecessary and inefficient use of HMSA and DSSH medical consultants. This duplication of effort is especially unnecessary in light of the fact that the personnel performing the State's Medicaid review function in many of Hawaii's hospitals are the same as those performing the review functions for PSRO (in those hospitals in which the PSRO, under Medicare, has allowed delegation of the review functions to the hospital or review committee.) Another area of duplication and inefficiency is that under the current approach, both DSSH and PSRO evaluate the utilization review committees in spite of the fact that the PSRO evaluation is more detailed, complete and thorough. Reviews by the DSSH utilization review committees also result in far less data collection. The PSRO reviews require and usually result in much more specialized data collection procedures. The resulting data provide the basis for additional utilization controls.

Thus, DSSH continues its own hospital utilization review system in spite of federal requirements for PSRO review, causing unnecessary expense to the State. Costs are further increased because only a portion of the DSSH reviews are paid for by the federal government. Virtually all of the cost of PSRO reviews are borne by the federal government, either in direct payments to the PSRO or through reimbursements to the hospitals.

DSSH has instituted three hospital utilization control procedures. The first conforms to federal regulations and is also a part of the PSRO system. This mandates that an approved length of stay form be completed by the attending physician in the institution and attached to the patient's record. The length of stay is established based upon the review procedures of the hospital's review committee. The second utilization

control procedure is an additional requirement of DSSH. This requires the attending physician to submit special requests for those cases in which the hospital stay will exceed five days. The third procedure requires that in cases in which a patient is to be discharged to a nursing home, the hospital's utilization review procedures serve as the basis to establish the appropriate level of care, e.g., whether the patient should be placed in a SNF, ICF, or be discharged to his or her residence.

Our study reviewed the effectiveness of the review process used by DSSH to control the length of stay in hospitals. This was measured by comparing the amount of time Hawaii's Medicaid patients are hospitalized with appropriate norms. Also reviewed was the process of establishing initial lengths of stay for hospital patients.

The lengths of stay in Hawaii were compared to Professional Activity Study (PAS) norms for the western region. These norms identify expected lengths of stay for various diagnosis for patients by sex and age group. The PAS norms are developed regionally from claims for hospital services from hospitals throughout the various regions in the United States. Hawaii is included in the western region and most, but not all, hospitals in Hawaii submit data that are used to develop the PAS norms.

The PAS norms are developed in four percentiles with each percentile representing the length of stay in days of a specified percentage of the cases for a given diagnosis for patients of the same sex and age. As an example, the 75th percentile length of stay for a given diagnosis might be four days. This means that in 75% of these cases, the hospital stays are expected to be four days or less. Normally, one would expect that lengths of stay for recipients would follow the norms, i.e., 75% of the cases would have stays less than or equal to the 75th percentile norm for their diagnosis, 50% would be equal or less than the 50th percentile norm, etc.

The actual lengths of stay for hospital inpatient services in Hawaii, based upon a sample of 446 paid claims, are not significantly longer than those for the same diagnosis, age and sex adjusted, when compared to the PAS norms for the western United States. For the diagnosis sampled, 25% should have exceeded the norm at the 75th percentile, however, 29.7% of the Hawaii Medicaid hospital stays studied exceeded the 75th PAS percentile norm.

One major deficiency in the current process is that not all hospital stays are appropriately certified. This occurs because patients expected to stay less than 5 days are excluded from certification due to state policy. As can be seen in Exhibit 9.1, over 69% of the stays were for 5 days or less. Thus, under current policy these stays do not require certification for length of stay and a large percentage of hospital admissions are ignored. If the PSRO program were responsible, all hospital admissions would be reviewed for appropriate length of stay.

A random sample of patient charts at a number of institutions indicated that not all length of stay certifications or continued stay approvals are consistently documented. This finding is consistent with the Pacific PSRO analysis of numerous hospitals.[4/]

Long-Term Care Reviews. Utilization control in the long-term care (LTC) facilities requires the utilization review apparatus to establish an appropriate level of care for those recipients to be placed in LTC facilities. The level of LTC must be identified prior to discharge from an acute care hospital.

DSSH has a contract with the Hawaii Foundation for Medical Care (HFMC) to provide the review function in many, but not all, LTC facilities. LTC facilities where utilization review committees have been approved by DSSH conduct their own review activities.

Through the contract with HFMC, physicians review skilled nursing facility patients at least every 90 days for appropriateness of their level of care and the adequacy of their medical care plans. For patients in intermediate care facilities, a similar review is done at least once a year. The review found that the level of care in the various LTC facilities was appropriately designated on the patient's records.

In conducting this portion of the review the appropriateness of the level of care for patients was discussed with the utilization review coordinator in a number of facilities. Those interviews and a sample review of medical records indicate that the Hawaii program continues to incur additional cost because some patients are in the more expensive SNF facilities rather than less expensive ICF locations. SNF administrators claim that there are insufficient ICF beds in Hawaii to which these patients may be transferred. These findings confirm an earlier study by DHEW regarding the same problem, in Audit Report No. 60208-09.

In that report DHEW indicated that patients were placed at inappropriate levels of care and recommended that the federal reimbursement be based on the lower level of care while the patient was waiting transfer to an available lower level of care bed. A simliar finding was mentioned in the exit draft of DHEW Audit Report No. 70208-09, but was later deleted when DSSH pointed out that there were insufficient facilities to which patients could be transferred.

The study and previous reports clearly show that this problem of providing appropriate level of care beds to recipients is a major cost burden for Hawaii's Medicaid program. The extent of the problem, its causes, and possible solutions are beyond the intended scope of this study.

One final aspect of the DSSH LTC review process relates to the review of the physical facilities and the general medical and personal care of the residents. These reviews are conducted periodically by DSSH's medical review teams as required by federal regulations. The study found that this review process is occurring. However, in all cases the facilities to be reviewed are given 48 hours advance notice. The advance notice has the potential for allowing sufficient time for the facilities to get ready for the inspection, thereby defeating the purpose of the inspections: namely, to determine whether the facility is continuously providing adequate care.

Ambulatory Care Review. The DSSH ambulatory care utilization control process currently consists of: (1) the prior authorization of selected outpatient procedures and (2) the review of paid claims by HMSA. There are numerous procedures which require prior authorization as a condition of the claim payment. Numerous procedures of other types of providers, such as dentists, also require prior authorization.

With the exception of the prior authorization for selected procedures and the review of paid claims, which is essentially statistical in nature, the study found that there is no systematic process for controlling the utilization of ambulatory care. Medical records from clinics, physician offices, etc. are not regularly reviewed to determine appropriateness of the services delivered to recipients and, as previously mentioned, prior authorizations are not adequately processed and controlled.

Recommendations

Control over unnecessary and inappropriate delivery of services is a major opportunity for the Medicaid program to exercise meaningful cost containment measures. There controls should be undertaken utilizing the most effective available resources at the lowest possible state administrative cost.

It is recommended that:

1. DSSH begin immediate negotiations with the Pacific PSRO to perform the hospital utilization review function for the Medicaid program. DSSH as part of its arrangements with the PSRO should establish procedures to monitor the activities of the PSRO.

2. DSSH nursing home facility and medical review procedures be revised to eliminate the practice of giving 48 hour prior notice.

3. DSSH undertake an analysis to resolve the problem of the lack of adequate intermediate care (ICF) facilities in Hawaii.

C. FRAUD AND ABUSE

Background

Fraud and abuse is the most pernicious form of loss of available resources for the Medicaid program. The legal definition of fraud is determined by reference to state statute. Generally, fraud differs from abusive practices in that in fraud the provider knowingly and with intent to obtain payment for which he/she is not entitled makes an effort to obtain reimbursement for services not rendered, rendered unnecessarily, or rendered at a level inappropriate for the medical needs of the recipient. Abusive practices may constitute on the surface the same actions, but there is no knowledge or intent to receive monies not considered due the provider.

On a nationwide level the problem has been identified as being far more prevalent than previously expected. 5/ Fraud appears to

be only the tip of the proverbial iceberg, with abusive practices seemingly accounting for additional drains on available Medicaid resources. The actual magnitude of the problem remains to be determined, but the need for strict and effective fraud and abuse control approaches has become clear. Most state legislatures, and the U.S. Congress, obviously concerned with rising Medicaid expenditures and alarming exposes, have placed significant pressure on state agencies to institute effective control procedures.

The seriousness of the fraud and abuse problems in the Medicaid program has been highlighted by recent Congressional action. P.L. 95-142, the Medicare-Medicaid Anti-Fraud and Abuse Act of 1977, was signed into law and became effective in October 1977. That Act increased the criminal penalties for Medicaid fraud and provided funds for state fraud and abuse control programs. The Act provides 90% funding for state fraud investigation units, but only when the unit is not under the direct control of the single agency in charge of the Medicaid program. A majority of states have placed the unit in the Office of the Attorney General.

Efforts to control fraud and abuse are increasing each day. As an example, the federal government has initiated an effort to review claims payment data on a nationwide basis. In conjunction with this effort, DHEW contracted with Arthur Young & Company to develop an automated fraud and abuse detection system called the Medical Exception Reporting System (MERS) for use by the state Medicaid programs. In addition, many states have developed specialized fraud and abuse investigation units and systems and have increased the number of field investigators. The techniques for identifying and controlling fraud are varied, complex and difficult, but nonetheless necessary, when one considers the potential for fraud and abuse and the magnitude of monies involved.

The procedures most commonly used to identify and control fraud and abuse include reviews of billing practices, investiga-

tions of leads and "tips" from disgruntled parties, field investigations of providers, and computerized reviews of paid claims. This computerized review of paid claims uses a component of the Medicaid Management Information System which is referred to as the Surveillance and Utilization Review System (SURS).

The prompt follow-up investigation and referral for prosecution of potential fraud and abuse cases is not only a control against future such behavior for the involved parties, but also discourages others who might attempt such actions. On the other hand, the lack of an effective fraud and abuse follow-up program invites others to defraud and abuse the program.

Findings

Under the contract with DSSH, HMSA is responsible for identifying potential cases of fraud and abuse. To accomplish this HMSA reviews claims from all providers, and reviews financial data from institutional providers.

Medical consultants at HMSA review provider activities examining the medical diagnosis and medical history of the recipient. If the medical consultant determines either fraud or abuse appears to exists, HMSA documents the case for follow-up by DSSH. DSSH is responsible for determining whether any of the cases referred to it by HMSA require specific remedies or are to be referred to the Attorney General for possible action.

DSSH has no organized system to conduct follow-up investigations of potential fraud and abuse cases. Potential cases referred to them by HMSA are filed in a haphazard fashion. The referrals are not logged in order to maintain control of the number of cases currently under consideration, their status, and final disposition.

Of the 47 cases referred by HMSA to DSSH in fiscal year 1976-1977, no documentation existed at DSSH as to what follow-up

action was taken in 38 cases. Six of the nine cases for which follow-action was taken were simply handled by sending letters to the involved providers. These letters merely called their attention to the questionable patterns of service delivery HMSA identified. Only three of the 47 cases brought to DSSH's attention were referred for further investigation and possible prosecution to investigatory or regulatory bodies. One case involving potential provider fraud was referred to the Attorney General. A case involving recipient drug abuse was referred to the Drug Enforcement Agency, and a case involving potential recipient abuse under the apparent knowledge of the attending physician was referred to the Hawaii Medical Association, where a letter of reprimand was issued to the physician censuring his methodology.

The only conviction resulting from these referrals was for a drug abuse charge to which the recipient pleaded guilty. There were no provider convictions.

The current process in DSSH for following up on potential fraud and abuse cases is inadequate. There are no established procedures for follow-up on the cases referred by HMSA nor is the responsiblity for follow-up assigned.

Implementation by the State of Public Law 95-142 was accomplished by Act 106, Session Laws of Hawaii 1978, which establishes a Medicaid fraud unit in the department of the attorney general. This act authorizes the unit to investigate and prosecute violations of state laws by providers of medical assistance, and appropriates $361,800 for this purpose for the present fiscal year. The unit was certified by the Department of Health, Education and Welfare effective July 1, 1978.

Under an agreement between DSSH and the attorney general, DSSH is obligated to conduct a preliminary investigation of suspected cases of fraud by providers and abuse or neglect of

patients in health care facilities receiving Medicaid funds. It is to refer to the unit all cases in which potential fraud or abuse of a criminal nature are indicated.[6] During its initial six months of operation, however, the fraud unit has received only one formal referral from DSSH.[7] This has been a major obstacle to the effective functioning of the unit.

Part of the problem lies with a lack of internal procedures within DSSH to efficiently process data gathered by HMSA and the department itself which could lead to referrals of suspected cases. HMSA performs a number of audit functions relating to provider activities as part of its continuing utilization review program. These include claims reviews, utilization profiles, annual audits of institutional providers, and provider validation visits. From this mass of data, HMSA prepares summaries designed to easily identify potential cases of fraud or abuse. The most glaring potential cases are put into narrative summaries for further investigation. In addition, HMSA mails explanation of benefits forms to all Medicaid beneficiaries every six weeks, in which beneficiaries are notified of their right to complain to the department with respect to any questionable claims by providers. All data gathered or solicited by HMSA are supplied directly to the department, which has responsibility for followup investigation and referral. However, no clear internal procedures exist to guide the department in processing the data and making referrals.

In addition, poor coordination exists between the department, the unit, and HMSA. No clear guidelines determine which data can or should be supplied directly by HMSA to the unit. There appears to be some confusion within the department as to the appropriate level of departmental input into the referral process. Moreover, the department has only one investigator to handle both recipient and provider fraud and abuse, an inadequate staff in view of the large volume of potential cases.

Part of the problem of poor coordination may be due to a real or imagined conflict of authority between the department, which has administrative control of the program, and the unit, which has authority to investigate and prosecute fraud and abuse. However, this problem could be readily remedied by cooperative administrative action to clearly define the lines of authority between the three agencies. Thus, for example, the department would retain the authority to impose administrative sanctions in cases which do not rise to the level of criminal fraud or abuse, while the unit would have wide latitude in the more serious cases to obtain data directly from HMSA, investigate, and prosecute.

Recommendations

The intent of the Medicare-Medicaid Anti-Fraud and Abuse Act is to strengthen the investigation and prosecution of violations of state fraud laws in connection with the provision of medical assistance and the activities of providers.

Since the role of the fraud control unit funded by the Medicare-Medicaid Anti-Fraud and Abuse Act of 1977 is not completely specified, an initial step in implementing such a unit should be to determine specifically how the various fraud and abuse identification and followup duties and necessary information support will be provided among the unit, DSSH and HMSA to achieve an effective and coordinated total effort.

It is recommended that:

1. DSSH develop and implement clear, formal guidelines for the assessment and investigation of data and referrals to the Medicaid fraud unit of the department of the attorney general. Such guidelines should expedite referrals to the unit and allow for maximum flexibility of the unit to exercise its legal judgment in those cases.

2. DSSH, the Medicaid fraud unit, and HMSA act in concert to clearly define lines of authority with respect to the gathering and supplying of data, investigation, and prosecution or imposition of administrative sanctions. Such cooperation should be formalized to the extent necessary, such as through modification of existing agreements or exchange of memorandums.

3. DSSH request additional personnel to upgrade its investigation and referral functions.

D. SURVEILLANCE AND UTILIZATION REPORTING SYSTEM (SURS)

Background

The principal functions performed in the Surveillance and Utilization Review Subsystem are as follows:

> (1) Develop a comprehensive statistical profile of health care delivery and utilization patterns,
>
> (2) Reveal suspected instances of fraud or abuse of the Medicaid program by individual providers and recipients, and
>
> (3) Provide information indicating the existence of any potential defects in the level of care or quality of service provided under the Medicaid program. 8/

The principal source of input for the Surveillance and Utilization Review Subsystem is in the file of paid claims from the Claims Processing Subsystem. Data from the Provider Subsystem and Recipient Subsystem are used to supply certain demographic and identification data on individual providers and recipients.

Findings

In Hawaii, many of the reports that are used to monitor and review utilization are prepared manually by HMSA, rather than being generated by the automated claims processing system. Many of the reports which could be available through the SURS system have not been programmed.

The system lacks detailed information concerning specific medical care provided to patients, especially ancillary services. In general, the SURS reports from the current Hawaii MMIS provide minimal information regarding the interrelationships between diagnosis, procedures, services, and providers. In addition, the SURS reports are currently limited to inpatient, physician, and drug service, with limited data availability for laboratory services.

Most reports presently produced are cost oriented as opposed to reporting units of service and analyzing service provided as it relates to diagnosis, age, and sex. While cost is important and germane to the program, service data is necessary for detailed utilization and fraud and abuse investigation.

It must be recognized that in Hawaii HMSA has knowledge of the activities of most, if not all, of the providers because of the relatively small numbers involved and participation of these providers in the many programs for which HMSA has responsiblity. As a result, medical consultants for HMSA constantly review complete profiles of the Medicaid program participants. In this way, under most circumstances, they can immediately spot irregularities or deviations from accepted practices.

Recommendations

The SURS system is the focal point for monitoring and controlling the delivery of services. Currently, HMSA is undertaking these activities through extensive reliance on manual applications based upon review of individual profiles and episodic statistical reports. An improvement to these approaches would be the development of an exception reporting system which would allow for automated analyses of paid claims to uncover problems as determined by pre-set exception criteria established by the program.

It is recommended that:

HMSA develop a Medical Exception Reporting System to be used in Medicaid claims analyses.

E. MANAGEMENT AND ADMINISTRATIVE REPORTING SYSTEMS (MARS)

Background

The principal functions of the Management and Administrative Reporting Subsystem (MARS) are as follows;

(1) Furnish the single state agency with information to support the management review, evaluation, and decision making process,

(2) Provide management with financial data for proper fiscal planning and control,

(3) Provide management with information to assist in the development of improved medical assistance policy and regulations,

(4) Monitor the progress of claims processing operations, including the status of provider payments,

(5) Analyze provider performance in terms of the extent and adequacy of participation,

(6) Analyze recipient participation in terms of the nature and extent of services received, and

(7) Provide the necessary data to support Federal reporting requirements.9/

The information in the reports generated by the Management and Administrative Reporting Subsystem is derived from basic data collected in the Recipient, Provider, and Claims Processing components of MMIS. On a periodic basis, key data is extracted from computer files in these subsystems and consolidated into the various management and administrative reports.

The reports produced by the Management and Administrative Reporting Subsystem are designed to satisfy information needs in four functional areas; (1) administration, (2) operations, (3) provider relations, and (4) recipient relations.

Findings

The Hawaii system lacks the ability to automatically produce information in many of the areas for which MARS was designed. As examples, the Hawaii system does not produce data to (1) identify recipient participation and services delivered by the geographical place of the recipients's residence, (2) project cost by service and prepare period-to-period cost comparison or budget-to actual comparisons, or (3) analyze developing third party liability patterns. The result of these limitations is that many analyses of this nature are not regularly performed because the data is not available or additional costs are incurred to manually obtain the data necessary for such analyses.

The Management and Administrative Reporting Subsystem is not producing those reports that would be most effective for

internal program management and operation. At present, numerous special reports, trend analysis reports, annual reports, payment reimbursement updating, and research and statistics for legislative or policy analysis, are manually generated, resulting in a lack of timeliness and excessive clerical cost. For example, all trend analyses for utilization patterns, except for the report on customary practices of physicians, are manually generated. All reports on incidences produced by HMSA also require manual assistance.

Complete data on long-term care activities such as medical review, placement, resources, facilities, licensure, inspection, payment, and patient profiles are not contained in the Hawaii MMIS.

Another major problem is that data from the CICS welfare information system and HMSA's Hawaii MMIS are not readily interrelated and utilized for administrative and planning purposes.

The information that does exist is fragmented, thus hampering efforts to analyze and evaluate potential courses of action regarding the total problem as opposed to only the cost and utilization of medical services.

For example, data are not available to relate medical payments by type and age of recipients to (1) other types of public assistance received by the recipients and (2) the recipients' geographical area of residence, e.g., census tract. Without such information it is not possible to analyze potential causal factors or relationships that influence the cost of the program.

This limitation is occuring because HMSA dose not have sufficient data supplied to it by DSSH's CICS' information system and conversely there is no means by which CICS can accept Hawaii MMIS data. Therefore, the program is hampered in undertaking optimum controls and the required comprehensive analyses for both the executive and legislative branches of Hawaii government.

Recommendations

In order to provide adequate internal administrative information for Medicaid and the total welfare environment in the State of Hawaii, an effective administrative information support system is required.

It is recommended that:

1. DSSH and HMSA undertake a comprehensive study to determine the information needs regarding the Medicaid program from the viewpoint of the State's total welfare effort. Specifically, DSSH should consider the value of information on costs and type of services provided by recipient category, age, and census tract. In this study, DSSH should determine the cost and benefits of automating additional management reporting functions now either performed manually or not available. The study should review the need for information in the following areas:

- Trend Analysis
- Forecasting, Planning and Budgeting
- Budget to Actual Comparison
- Medicare Participation and Buy-in Analysis
- Provider Payments and Cost Settlements
- Third Party Payment Analysis
- Provider Class Summary Profiles
- Cost vs. Utilization Analysis
- Demographics Analysis

2. A systems analysis be undertaken to determine the best means of acquiring these reports. The HMSA-designed "MMIS" is primarily a claims processing system. The bulk of critical data, especially the recipient files and accompanying nonmedical data,

reside in the CICS welfare system. It is imperative to evaluate the extent to which it would prove more efficient to have HMSA provide Medicaid data to the CICS system which would then generate the required overall Medicaid and welfare system reports.

EXHIBIT 9.1

LENGTH OF HOSPITAL STAYS
FOR HAWAII MEDICAID PATIENTS IN A SELECTED SAMPLE

Length of Stay (days)	Number in Sample	Percentage of total	Percentage Not Certified as to allowable length of stay
1	87	19.5%	
2	81	18.2	
3	71	15.9	
4	47	10.5	
5 (current review level)	22	5.0	69.1%
6	16	3.6	
7	19	4.3	
8	18	4.0	
9 or more	85	19.0	
	446	100.0	

Exhibit 9.1 A table showing number of patients in sample and their length of stay. See text for explanation.

Source: Arthur Young & Company study sample.

CHAPTER NINE - FOOTNOTES

1/ Public Law 92-603.

2/ Report 92-1230, U.S. Senate Finance Committee, September 26, 1972, p. 257 - Section B. Principal Medicare-Medicaid Provisions.

3/ Personal conversations with N.Y. Medicaid officials.

4/ Correspondence from the Pacific PSRO to Queen's Medical Center, June 22, 1977, and Memorial Hospital, July 26, 1977, reporting on the findings of the PSRO Survey Team regarding the capability of the institutions to perform utilization reviews in accordance with PSRO requirements.

5/ "What We've Learned from the Medicaid Mess," American Medical News, October 25, 1976.

6/ Agreement between DSSH and the Department of the Attorney General, May 12, 1978, p. 2.

7/ Rick Eichor, Director, Medicaid Fraud Control Unit, Office of the Attorney General; and Robert Millar, Administrator, Medical Care Administration Service, Department of Social Services and Housing.

8/ Op. cit., "MMIS."

9/ Ibid.

PART III. DESCRIPTION OF ALTERNATIVE COST CONTAINMENT STRATEGIES

As a result of spiraling expenditures, many states have resorted to a variety of approaches intended to contain the expense of providing health services to the indigent. Appendix C lists selected changes made by various states in an effort to control the cost of their medical programs. In general, the actions by other states to control costs fall into three categories: (1) changes in the services provided, (2) elimination of services, and (3) implementation of copayment for services. The purpose of this part of the report is to describe some of the cost containment measures used by other states and, in view of the current Hawaii Medicaid program offered, suggest potential alternative cost containment "strategies" that might be applied in Hawaii.

Without a planned, methodical approach to cost containment, Hawaii could face the same financial problems now facing many of the Medicaid programs in other states. Some of these states are now having difficulties in funding the Medicaid program without jeopardizing other vitally necessary programs and/or the overall financial posture of the state. The response of the states upon reaching this position has typically been to diminish expenditures by engaging in crash, short-term cuts in benefits for recipients and payments to providers. This type of reactionary activity has caused confusion among providers and recipients as to what services are offered by the program, stresses in the overall health care system because of critial services for Medicaid recipients being eliminated, imposing of a financial burden on providers who rely on adequate public funds for continued operation, and a hardship on the Medicaid recipient.

Hawaii has a number of unique opportunities regarding cost containment. The cost of the Medicaid program has not reached the point where the State is unable to fund it. Therefore, the State

still has the opportunity and flexibility to develop a planned approach to cost containment rather than being forced into a crash cost cutting program. The providers and recipients in Hawaii have not been subjected to poorly planned and ineffective cost cutting. Hopefully, this provides for an environment in which sound planning and compromise among the providers and the State can be undertaken with all parties aware of the necessity of cost containment. Finally, Hawaii is in a position to learn from the mistakes and problems experienced by other states that have implemented various cost containment measures. Those measures which have appeared successful can be evaluated and tailored to fit Hawaii's unique circumstances. Those measures which have yielded limited, marginal results or were ineffective can be thoroughly analyzed to determine their strengths and weaknesses, and wherever appropriate, redesigned to yield better results for Hawaii.

Conceptually the State has two basic cost containment strategies available.

- Improve program administration through reduction of improper payments, maximization of other third party payments available to Medicaid patients, reduction of fraud and abuse, improved claims processing activities, better utilization, etc.
- Develop and implement approaches to contain the cost of the services rendered to recipients.

The subsequent chapters of this Part describe alternative "strategies" available to Hawaii to control the cost of services. The cost containment alternatives for institutional providers and noninstitutional providers have been separated because of the widely different methods by which their services are rendered and the nature of the reimbursement methods. In describing the alternative cost control strategies, the primary objective of this Part is to suggest alternatives for consideration and further analysis as appropriate. The scope of the study did not intend

that detailed analysis be conducted of the alternatives available. Therefore, before any containment measures are implemented, systematic analysis is required to ensure that the selected alternatives are desirable and appear to be potentially successful in the Hawaii environment. Accordingly, Arthur Young & Company cannot at this time, without extensive study and analysis, except in those instances of direct program operations, recommend any specific alternative for immediate implementation.

CHAPTER 10. ALTERNATIVES FOR COST CONTAINMENT FOR INSTITUTIONAL PURPOSES

This chapter focuses upon strategies available for cost containment for institutional providers. Institutional providers, as the term is commonly used, includes hospitals, skilled nursing facilities (SNF's), intermediate care facilities (ICF's), and home health care agencies. Background material is provided which illustrates the alternatives used by other states in an attempt to contain institutional costs. Discussed in this chapter are: (1) alternatives to the current Hawaii approach used to reimburse institutional providers, (2) alternatives associated with changing the rate structure upon which payments to institutional providers are based, (3) the potential impact on costs of increasing the productivity of institutional providers, and (4) cost considerations regarding the utilization of institutions and the need to develop alternatives to institutional care as a method of reducing costs. Finally, a summary of experiences of other states using various cost control methods is provided.

The enabling legislation of the Medicaid program mandated that institutional providers be paid their full allowable cost of providing services to Medicaid patients. The 1972 amendments to the Social Security Act (P.L. 92-603) were directed at curbing cost escalation in the program and introduced the use of experimental reimbursement methods. Some of these methods had the effect of potentially allowing the States to reimburse institutions at less than their reasonable cost. More important, however, was the inducement to institutions to provide incentives to contain their costs while still providing an optimum level of care. To use these procedures for reimbursement of institutional services, the State system must have reimbursement attributes which include;

- Incentives for efficiency and economy.
- Approval by the Secretary of DHEW.

- Controls which will ensure that reimbursement for providers will not exceed that which would result by the application of the Medicare reimbursement methodology.

Hawaii's Medicaid reimbursement system for institutions as well as the system used by the Medicare program is a retrospective reimbursement system which reimburses institutions at the lower of their costs or charges. This means that institutional providers are paid the lesser of (1) the costs incurred in delivering the services when costs are less than the customary charges to typical patients regardless of their means of payment, or (2) the amount normally charged a typical patient when these charges are less than the provider's cost. There is one exception to this rule. In the case of public institutions, if charges are less than 50% of costs, the program will reimburse such public providers their costs of providing services. Currently in Hawaii, costs are determined after the services are rendered. The providers file a statement of cost with HMSA which is used to substantiate their costs and allow for a final cost settlement between the Medicaid program and the institutional provider. This is necessary because the bills submitted by the institution for care rendered an individual recipient only reflect an estimate or close approximation of its costs. Only at year-end when the institution can calculate its actual allowable total cost can a valid reimbursement be truly established. At the year-end reconciliation between an institution and HMSA, adjustment to the amounts paid during the year to conform with total allowable costs are undertaken.

Retrospective reimbursement based on actual costs has no built in incentives to encourage institutions to reduce or contain costs. To a large extent and with few controls, hospitals can provide additional specialized services, expensive technologies, luxurious environments, and operate with less than optimal productivity, yet still be reimbursed for all of their allowable costs under the current retrospective reimbursement system. It is obvious that this form of reimbursement methodology does not provide for maximum incentives for efficiency and cost containment.

There are two principal alternatives to retrospective reimbursement: (1) Prospective reimbursement and (2) rate regulation.

A. PROSPECTIVE REIMBURSEMENT

Prospective reimbursement is a method of paying for institutional services in which a rate of payment is established before services are rendered. This differs from retrospective reimbursement in which the provider is reimbursed after the provision of services at allowable cost with only minimal regard to the level of institutional expenditures. Under retrospective reimbursement only two major tests are necessary: (1) The costs be allowable, i.e. expenditures of the institution are deemed acceptable and within the program guidelines of Medicaid, and (2) the expenditures be prudent, i.e., have some reasonable relationship to the marketplace. When providers are paid on the basis of prospective rates under various methodologies in use, they are committed, regardless of their actual costs incurred, to the agreed pre-determined reimbursement rates. The hypothesis put forth in support of this approach is that there is then a powerful incentive for providers to contain costs so as not to exceed the amount that they will be paid.

Prospective rate setting under various methodologies is typically established by having the institution prepare a budget of planned expenditures. Once the budget, on which the prospective rate is based, is established and approved by reference to a predetermined set of guidelines, it becomes the basis of reimbursing the hospital for the period covered by the budget.

Several variations based upon the prospective approach have been implemented. One variation gaining acceptance is to have the provider establish its prospective budget based on the operating conditions that exist when the budget is prepared. The institution is subjected to a methods improvement study to identify those areas where it is anticipated that costs can be reduced or avoided

during the period covered by the prospective budget. The results of the methods improvement study are then reflected in a revised budget referred to as a "prospective improvement budget." If the institution operates below the approved budget, it is entitled to retain some or all of the savings.

Proponents of this approach claim that it can provide significant incentives for institutions to contain their costs because the institutions "share" in the savings. In this manner, both the State and the institution benefit. The State benefits because the rate will be contained in its growth each year. The Medicaid program benefits because it can budget, since it knows in advance what its institutional costs will be. The hospital benefits because it is guaranteed a payment base and should it operate at below budget it can retain a portion of the savings for use in supporting other institutional requirements.

B. COST CONTROL EXPERIMENTS AND DEMONSTRATIONS

Under the authority of the 1972 amendments to the Social Security Act, a number of studies, experiments, and demonstrations in prospective/incentive reimbursement have been carried out by the Social Security Administration. These were summarized in an initial report to the U.S. Congress in August, 1974.

- Prospective reimbursement brings increased predictability of costs and revenues for third-party payors and for providers. This is helpful to both parties as it facilitates fiscal planning and reduces cash flow problems.

- The development of better cost and utilization information is a prerequisite to the equitable determination of hospital rates. The availability of such information offers side benefits to hospital managers concerned with bringing a greater degree of rationality to the health care system.

- Bringing knowledgeable outside reviewers into the rate setting process forces hospitals out of their traditional isolation from problems of rising costs. Detailed reviews of budgets can serve as a powerful educational stimulus to hospital management and trustees, can motivate administrators to demonstrate improved performance, and offers the possibility of increased public accountability.

- The process of establishing rates prospectively requires both hospital administrators and rate setters to more critically examine the specific elements that make up hospital costs. Improved budgeting and program planning become necessary and new expenditures are apt to be made on an informed basis than under a retrospective reimbursement system where costs will always be recovered regardless of their level

- Rational health planning controls play an essential role in some prospective rate setting systems. Such systems attempt to address the matter of what technological improvements and new programs should be funded. Unnecessary capital expansion under either a prospective or retrospective system leads to excessive costs resulting from too many beds and thus greater inefficiency. A number of systems have established guidelines governing the expansion of services and physical facilities.

- Attempts to set rates in a manner that allows for justifiable improvements in patient care, while recognizing the need to avoid the runaway growth of new medical services and programs, may be coupled with the reduction of unneeded and underutilized services while maintaining the quality of care provided.

- Some types of cost increases are clearly beyond the power of providers to control or rate setters to predict particularly in a period of rapid inflation. Other discrepancies between the prospective rate and actual costs may result from unpredictable changes in volume of services, or from exogenous factors such as costs associated with compliance to new federal or state laws and regulations. Automatic adjustment factors and/or automatic provisions for rate reopening and appeal can be built into the rate setting mechanism to provide for such contingencies. There are also areas where costs may be found to be excessive but where the hospital administrator's power to control them is distinctly limited. Costs associated with the many departments and activities traditionally under the control of physicians are the most obvious case in point. Few of the prospective reimbursement programs claim to have found ways to deal successfully with this problem, although involving the professional medical community in the rate

setting process appears to be an obvious method of dealing with that problem.

- Although no prospective reimbursement program has completely incorporated the use of productivity studies into the rate setting process, some experiments along these lines are being planned and implemented.

- The more successful approaches attempt to induce providers to change or reduce costs without dictating precisely that change must take place.

- Apparently, responsibility and accountability for the operations of providers must remain with providers. Some industry spokesmen believe that a major shift of operational responsibility from providers to the prospective system could defeat the cost containment objectives in the long run. Agreed on financial performance that reflects reductions in the hospital's original cost projections can provide the hospital administrator an impetus for change without the third party having to dictate precisely what the change should be.

- To date, prospective payment systems have failed to systematically assess the cost effectiveness of their results. The absence of such assessment precludes determination of what specific savings might be expected from a given prospective system. 1/

The observations of the 1974 DHEW analysis have basically been confirmed in a more recent study. 2/ That study concluded that approaches that set rates prospectively "have been moderately successful in lessening the pace of hospital cost inflation." The study noted that the impact of such efforts to date have been a 1-to-3% annual savings which in all cases was clearly insufficient to bring the rate of hospital cost increases in line with inflation in other sectors of the economy. Nevertheless, such savings compounded over time could offer a substantial benefit to the program.

C. RATE CONTROL

Many proponents of prospective reimbursement consider it to be an incentive for institutions to reduce costs. This assumption may be only partially valid. As with any budget-oriented reimbursement system, the approach will be for the most part highly dependent on the validity of the budget which determines the future reimbursement rates.

If the budget process is not properly monitored and the resulting budget not properly scrutinized, the result may be only a budget that overstates anticipated costs. This overstated budget then minimizes rate control because it allows the institutions to perform easily at or below the budget. Furthermore, it may allow the institution to collect unwarranted incentive awards. One method for controlling this problem is through formal rate review proceedings.

More than half of the states have adopted rate review legislation for institutions. The adoption of the approach has either been through the legislative process or by acceptance of a voluntary program established by the institutions, third party payors and government agencies. More than 34% of the acute general hospitals in the United States presently are subject to some form of rate review at the state level. 3/

Rate review is the process by which a regulatory body, public, quasi-public or voluntary, reviews the data supporting proposed institutional budgets and resulting rates. It then approves or denies the rates based on its analysis. Basically, two types of rate review programs are in effect, mandatory and voluntary. Mandatory rate review programs differ from voluntary programs inasmuch as the mandatory systems have the legal power to

make the determination of the review body binding. In voluntary programs the decision of the review body is merely advisory in nature and not legally binding. Evaluation of these programs show that they have experienced varying degrees of success in containing costs.

A 1974 study indicated that the rate increases in hospital expenditures were reduced in those states with voluntary rate review programs. That study indicated that in states with mandatory rate review procedures, the increase in rate of hospital expenditures were higher than the increases in states with voluntary rate review and also in states without rate review programs. However the study had one major limitation, at the time of the study some of the approaches evaluated had been fully operational for only a limited period of time.

A subsequent study conducted in 1976 indicated that mandatory programs were more effective at controlling costs. 4/ However, all studies done to date are suspect because of limited study design and control. As a result, DHEW is currently planning a comprehensive evaluation of nine major prospective rate setting programs with an objective of "ascertaining the impact of hospital rate regulations on health expenditures in general and the expenditures for hospital care in particular." 5/

The available data suggests, although not conclusively, that rate review can be a meaningful approach to institutional cost containment. The following benefits are those cited in favor of rate review programs:

- Reduced costs to the state by causing providers to employ cost-cutting and cost containment measures. Such measures are usually necessary for providers to meet the rate review criteria. By reducing or slowing institutional costs, the rate of increase in Medicaid payments can be contained.

- A stabilization of health care costs for all patients.

- Improved management by institutions by providing them targets towards which management may strive as opposed to the retrospective reimbursement method which provides minimal incentives for cost containment.

As an example of rate review activities, Appendix D provides information about the Rate Review Commission used for rate regulation by the State of Washington. This commission provides for a balance of interests between providers, consumers, labor, and business interests. This commission has no mandated representation from the insurance industry. This is important to note because the role of the insurance industry is significant in health care expenditures. They play a preeminent role in establishing rate structures, influencing the cost of health care in general, and determining the methods of financing the health care industry. Regardless of whether a voluntary or mandatory program is used, the rate review concept is an essential ingredient of a prospective reimbursement system. The review concept provides the control by requiring the providers to justify rate determinations before an independent body.

D. FIXED RATE PAYMENT BASES

There are options available for paying for health care services other than utilizing cost based reimbursement methods. The allowable bases on which payment can be made by the Medicaid program include use of reimbursement rates limited to the maximum allowable amount as determined by the Medicare program, fixed rate schedules (related to cost), and other experimental methods which have been approved by the Secretary of DHEW.

On a nationwide basis, the various Medicaid programs cover the entire spectrum of allowable payment methods. Any change

from Hawaii's current payment basis, i.e. retrospective reimbursement based on cost or charges, whichever is lower, (the same formula used by the Medicare program) to a different payment basis will require approval by the Secretary of DHEW.

The calculation of a fixed rate to be used by the institution submitting bills is usually based upon the institution's: (1) average or slightly above average cost data, (2) historical cost data, or (3) cost forecasts based on reimbursement trends. This type of reimbursement actually results in control of cash flow for an interim period because the State may be paying the hospital less than its cost until reconciliation takes place. Ultimately, the institution must get its allowable costs, but this may be delayed for long periods until the end of year reconciliation occurs. This approach can result in inequities and be injurious to the institution because any reimbursement methodology which is not based on a provider's actual reasonable costs means that some providers will be overpaid while others are underpaid. Thus some providers will not recover their costs for an extended period and experience a cash flow problem while others will get use of funds they may not be entitled to. The use of fixed rates typically results in reimbursement of providers at a rate less than the cost of care for varying periods. This is particularly true during periods of rapid cost escalation. The primary advantage of fixed rates for the State is that it tends to limit institutional expenditures, require them to be careful in regard to expenditures, and slow down cash payments by the State.

E. PRODUCTIVITY MANAGEMENT

An opportunity to control costs exists by increasing the productivity of institutional providers. Since the largest segment of provider costs is labor, introduction of methods for improving employee productivity can generate cost savings to providers.

To the extent that providers base their rates on the cost of providing services, productivity improvements will reduce costs to the Medicaid program as well as to other third party sources of payment for patients.

In general, studies to improve productivity involve the detailed analysis of various ways to increase efficiency. These studies include analysis of the means to: (1) improve methods, (2) use manpower more effectively, (3) eliminate non-essential services and jobs and, (4) pool services with other institutions.

Rates established with an emphasis on improvement of productivity can be used to develop a sense of importance upon providers to improve their efficiency. If a provider operates an efficient facility and performs better than a predetermined and agreed upon standard, the savings generated are retained by the provider. If alternatively, the provider is inefficient and cannot perform at or above standard, the rate structure will penalize the institution and require it to pinpoint problem areas where costs are higher than planned. The institution is in this way given motivation to install improvements in order to bring costs in line with budgeted amounts.

Although a reimbursement system based on the use of standards can be effective it is complex and requires a major effort to operate. Support by an institution's management of productivity studies is essential. Since many productivity studies are instituted because of outside pressures from rate commissions and legislatures, with the objective of controlling costs, management may not be fully supportive of efforts to increase productivity. The analysis and standard setting process is both time consuming and expensive, the levels of which depend upon the number, sizes and types of institutions involved. Finally, the system is difficult and expensive to maintain, especially in

a rapidly changing environment which typifies the health care system.

In spite of these problems, many health care professionals consider productivity improvement coupled with rate review as one of the most sound approaches to containing costs. Supporters of this approach view the savings and improved management control from the use of standards to outweigh the program costs. They further maintain that consistently generated and applied standards are an effective way to compare cost among similar institutions. Comparative data can be used by rate regulatory commissions, state officials and legislators, and other parties interested in improving institutional cost control. Again as mentioned before, no documented evidence exists supporting their cost containment claims and the evidence to date is more anecdotal than empirical.

F. INSTITUTIONAL UTILIZATION PROGRAMS

In many parts of the county there are a surplus of hospital beds. Some areas are experiencing overal occupancies rates as low as 50 or 60 percent of capacity. Low hospital institutional utilization increases costs, especially fixed and semi-variable costs for which it must receive reimbursement, because the institutions' allowable costs are allocated to a diminished number of patient days than would be the case with agreater use of the facilities. Furthermore, in a hospital, its allowable costs, both fixed and variable, do not directly relate to service demands and adjustments in costs to the institution may require significant time before they can be reduced to reflect service requirements. At present, Hawaii has a number of hospitals with low utilization, particularly in the outer island.

In comparison to the overbedding for acute care facilities there is a substantial shortage of intermediate care facility beds

throughout the islands. This imbalance is translated to higher costs for medical care because many patients are now retained in acute care hospitals because of a shortage of beds at a lower level of care. This shortage is particularly acute for ICF beds in Hawaii and impacts the Medicaid program to a major extent because of the extensive requirements for ICF beds by Medicaid patients.

At present, the federal and state regulations which constrain changing acute care beds to nursing beds on a need basis, are among some of the many factors which interplay to make solutions considerably difficult. No simple, unidimensional solution seems to have worked elsewhere. Besides the numerous problems internal to the health care system, there are considerably external political, social and economic pressures which must be dealt with prior to the adoption of any short or long range strategy. It is imperative that these concerns be appreciated because in Hawaii only an organized effort supported at the highest public and private levels provides any chance for successful solutions to this complex issue.

G. CONCLUSION

The overall strategy for controlling the cost of institutional services includes a variety of approaches that focus on the different factors that influence institutional costs. Certain alternatives, such as increasing the utilization of facilities or improving the movement of patients to lower level of care, require changes in the overall structure of the health care industry in Hawaii. The basic question that must be answered in selecting the most effective strategy is what are the characteristics which will make a cost containment approach most effective and acceptable for the Hawaii Medicaid program. Of utmost importance is providing the mechanism which determines which institutions will participate, and the nature of the basis for their participa-

tion. Since all institutions in the State participate in the Medicaid program, it follows that any program developed to impact Medicaid should involve all institutional providers.

A second characteristic to be considered is the nature of the incentive provided to contain costs. Obviously, a system which would incorporate an incentive component can be expected to be more acceptable. The issue is the manner and extent by which the providers and the State share in the savings created when a provider's actual costs are less than those which were budgeted. Given the current attitudes and direction of the public and private sector, the incentive approach coupled with prospective cost reimbursement seems to be most acceptable.

A third characteristic relates to the method to be used to determine costs. In this area the current Medicare formula must be modified within the context of the reimbursement process. This area requires significant compromise among the payors and providers and will require extensive study and development prior to the development of any reimbursement approach.

CHAPTER TEN - FOOTNOTES

1/ Prospective Reimbursement Studies, Experiments, and Demonstrations, A Report to the United States Congress, Social Security Administration, DHEW, August 1974.

2/ Hospital Reimbursement Research, Research in Health Care Financing, Spring/Summer 1977, Trudi W. Galblum. HEW Publication No. (SSA) 77-11901, 1977.

3/ Prospective Rate Setting, "Topics in Health Care Financing," Vol. 3, No. 2, Winter 1976, pp. 2-3, ICF Incorporated, General Impact of Hospital Rate Regulations on Changes in Hospital Expenditures and Revenues, 1974.

4/ Research in Health Care Financing, Spring/Summer 1977, DHEW July 1977.

5/ RFP No. HCFA-78-00R0-02/FM, DHEW, Health Care Financing Administration, October 1977.

CHAPTER 11. ALTERNATIVES FOR COST CONTAINMENT FOR NONINSTITUTIONAL PROVIDERS

This section reviews alternative cost containment approaches available for payment to non-institutional providers. These providers are more correctly referred to as program participants and include individual and group professional practitioners such as physicians, dentists, podiatrists and optometrists. Discussed are (1) the available methodologies for paying program participants (noninstitutional providers), and (2) controls that can be used to restrain the provision.

A. PAYMENTS TO PRACTITIONERS

Payments to participants in the various Medicaid programs are based upon one of three available methodologies. These include:

- Usual and customary rates (UCR) with a maximum equal to the maximum allowable Medicare rate;
- UCR with a maximum less than the maximum allowable Medicare rate;
- Fixed fee schedules prescribed by the state.

Hawaii pays participants on the basis of UCR with a maximum equal to the equivalent Medicare rate for the service. This is the result of Act 150, passed in 1976, which changed Hawaii's payment methodology from a fixed fee schedule to the UCR basis.

Either of the two methodologies not being used by Hawaii can result in equal or lower expenditures for participant services depending on the level at which the fee schedules are set. However, before any change is made several issues must be studied and evaluated.

Among the critical questions which must be analyzed are the following:

- Would a system that resulted in lower payments cause the participants to drop out of the program or at least participate to a lesser degree, e.g., would significantly less care be available to the Medicaid recipient population?
- Would there be a tendency by participants to order more services, and where possible, bill for more expensive services?
- Would beneficiaries be forced to increase utilization of hospital outpatient facilities in lieu of the normally less expensive physicians' and dentists' officers?

The Illinois Economic and Fiscal Commission in a recent study looked into the first two questions. Physician Medicaid rates in Illinois have been frozen since 1971. During the period of 1972 to 1975, the percentage of Illinois physicians participating in the Medicaid program grew from 31 percent in 1971 to approximately 43 percent in 1975. That study states:

> "Furthermore, a recent national study of physician participation in Medicaid programs has found no apparant relation between the type of reimbursement mechanism used by states and the level of doctor participation in the program. That is, whether a state paid full usual and customary fees, usual and customary fees up to a maximum ... or flat rates had no effect on the proportion of that state's physicians who chose to participate in Medicaid." 1/

While the Illinois data is not conclusive, it suggests that participants will not drop out of the program entirely due to lower than usual reimbursement rates. The Illinois study did show, however, that during the freeze, physicians changed their Medicaid billing patterns and where possible, billed for more expensive procedures. Part of this problem relates to an imprecisely defined list of procedures which allows a high degree of latitude in submitting payment invoices.

The final question, determining whether a shift from participants' offices to outpatient clinics will occur, is the most difficult to answer. No studies have been conducted that focus on this question.

Although Hawaii recently eliminated fixed fees as a method of paying participants, and implementing a fixed fee schedule is a highly charged political question, there can be no question that fixed fee schedules definitely decrease cost and control increases when they are set to reimburse at less than UCR rates. Another alternative would be to continue with the basic UCR rate structure, but to reduce the maximum that would be paid. This could be done by not updating the 1975 rates currently used, thereby not reflecting inflation since 1975. It is estimated that not updating the rates from the 1975 base could result in cost containment of approximately $5 to 7 million in fiscal 1979. Either alternative to current methods raises significant political issues. There is no doubt that costs could be reduced, but at what program stress, what degree of alienation of participants, and what impact on quality of care, are problems not easily resolved.

B. USE OF PHYSICIAN SERVICES

One of the more costly forms of program utilization is the uncontrolled utilization of physicians' services by program recipients. There are for all practical purposes no controls over the use of physician and participant services except for prior authorization. As a result, the program cost for physician and practitioner services depends to a large degree on use or abuse by recipients. This problem transcends Medicaid and is one of the most perplexing issues in all of health care. Some states, in recognition of the lack of control over the total cost of participant services, have imposed various arbitrary limits on the amount of service a recipient may use. The primary techniques

used include: requiring prior authorization for all services for a recipient when the aggregate amount exceeds a predetermined level; limiting a recipient to a specific number of physicial hospital visits; limiting the type and number of procedures which can be performed in the practitioners' offices (e.g., ambulatory surgery, laboratory tests, eye examinations); and limiting the scope of participant services to only mandatory services as required by Medicaid.

C. CONCLUSION

The principal options available to reduce participant costs are: (1) arbitrarily reducing the amounts paid for services by selecting a method that will pay less than the amount paid under the usual and customary approach, and (2) restricting the use of services by recipients. The issues involved in paying participants is complicated and is primarily one of public policy balancing the use of resources against the relationships with participants who are a crucial component of the Medicaid program.

The effectiveness of restricting use of services by recipients is dependent on the patterns of usage by recipients and the specific restrictions that might be imposed. Evaluation of specific potential restrictions is again a public policy issue which requires detailed assessment as to the potential impact in Hawaii.

However, three crucial issues need immediate review.

First, DSSH must determine its policy in regard to the adjustment of the 1975 rate structure used to pay physicians and dentists. The cost implications must be determined and a decision made as to modification.

Second, DSSH must review its prior approval program in the total context of what procedures really require prior authorization and how to control services used by recipients.

Finally, DSSH should study its optional services and medically-needy program and make recommendations to the legislature on the impact of these services on future cost projections in view of limited resources.

CHAPTER ELEVEN - FOOTNOTE

1/ Medicaid Costs and Controls: An Analysis, Illinois Economic and Fiscal Commission, December 1976, p. 38.

CHAPTER 12. COST SHARING AND CO-PAYMENT

A. PATIENT COST SHARING

Patient cost sharing has been touted as a control against unwarranted use of medical services. However, to date no incontrovertible evidence or study has been provided to prove this contention. Its use as a control assumes that recipients will not frivolously use medical services should they be required to bear a portion of the cost.

Patient cost sharing is normally accomplished in one of three ways: through co-payments, deductibles, or enrollment fees. The first, co-payment, requires the recipient to pay a nominal portion of non-required services as established in Federal regulations. Federal regulations do not allow the state to impose cost-sharing for mandated services in the categorically-needy program.1/ Co-payments may be either a percentage of the cost or a fixed amount based on the service rendered (i.e., drug co-payment might, for example, be lower than the co-payment required for dentures).

The second approach, deductible payment, places a ceiling on the amount the recipient pays regardless of how many services are delivered. Deductibles usually are for the amount of initial expenditures for medical expenses incurred in a year. The deductible amount can be set at any level, e.g. the first $50, $100, etc. of medical expenses per year.

The third approach, enrollment fees, requires the recipient to pay a nominal amount or premium for the opportunity to be served by the program. It is important to note that enrollment fees can only be applied to the medically-needy program category. Federal regulation prohibits this method under any circumstance for categorically-needy recipients.2/

Another form of patient cost sharing is found in the medically-needy program and certain supplemental security income groups (SSI). Under this approach, the medically-needy recipient or recipient receiving federal supplemental security income pays all costs of medical care until his income as a result of increasing medical expenses is reduced to the subsistance level defined by the state. Once the recipient's available resources have reached this level the program pays for further medical expense. For example, if the recipient had a net resource of $350 per month and the basic subsistence level was $300, the recipient would pay the first $50 of medical expenses incurred each month and the program would pay the balance.3/

B. CO-PAYMENT

The Medicaid program may require recipients to share in the cost of the program by charging a co-payment amount for services rendered to the recipient. Federal regulations, however, place certain limitations and controls on this practice.

- An enrollment fee or similar charge (a fee charged to enroll the recipient in the program such as a premium for insurance) cannot be charged the categorically-needy, but can be required for the medically-needy.

- Cost sharing or similar charges cannot be required of the categorically-needy for mandatory services. The medically-needy and certain recipients of supplemental security income can be required to pay a portion of the cost for all services. The categorically-needy can be required to pay a portion of only the optional services.

Typically, in states using co-payments, very nominal fees of $1.00 or less are charged the categorically-needy for optional services and the medically-needy for all services. The cost impact of such fees in Hawaii can be highlighted by examining the drug portion of the program. Had even $.50 been charged for

each prescription filled by the Hawaii program in 1977, the program would have recovered $220,755. There are specific limits set by federal regulations on the amounts that can be charged the recipient for any particular service.4/

Hawaii currently requires co-payment only by the medically needy. It is generally accepted that under co-payment most persons exercise some self control over utilization. This in turn helps to contain costs beyond the costs offset by the amount charged to the recipients. Yet, when it comes to introducing co-payment for Medicaid, hotly debated emotionally charged situations are encountered. Use of such an approach is considered harsh, oppressive, and lacking in consideration for the plight of the needy. The argument is put forth that categorical recipients are not given additional resources to compensate for the increased, cost nor are the conditions of eligibility changed for the medically-needy. A report prepared in January 1976, for use by the Subcommittee on Health and the Environment, Committee on Interstate and Foreign Commerce of the U.S. House of Representatives, indicates that the following states make the following co-payment provisions:

Alabama - Categorically-needy recipients only. Prescription drugs - co-payment of $.50 per perscription and refill.

Arkansas - Categorically and medically-needy recipients. Prescription drugs - co-payment of $.50 per prescription.

Georgia - Categorically-needy recipients only. Prescription drugs - co-payment of $.50 per prescription. Co-payments also imposed on ambulance services, durable medical equipment, and orthotic/prosthetic services.

Maryland - Categorically-needy and medically needy. Drugs - co-payment of $.50 per prescription.

Montana - Categorically-needy and medically-needy recipients. Prescription drugs - co-payment of $.50 per prescription, except for institutionalized persons.

New Jersey - Categorically-needy recipients only. Prescription drugs - co-payment of $.25 per prescription.

North Carolina - Categorically-needy and medically-needy recipients. Legend drugs and insulin - $.50 per prescription; optical supplies and services - $2 per visit; chiropractic services - $1 per visit; dental services - $2 per visit. Medically needy recipients - Inpatient hospital - $2 per inpatient day; outpatient - $1 per outpatient visit; physician - $1 per visit.

Virginia - Categorically-needy and medically-needy recipients. Prescription drugs - co-payment of $.50 per perscription and refills dispensed on outpatient basis; eyeglasses - co-payment of $2 for each pair, and for repair or replacement of parts costing more than $5.

Additionally, the Kansas Medicaid program established co-payment on drugs effective July 1, 1976. Early in 1977, the program's drug expenditures were compared to a similar period when co-payment was not required. Drug expenditures increased only 1 1/2 percent, while the number of recipients of pharmacy services increased 5.8%. The number of prescriptions dispensed, however, decreased 3.4%. This data highlights the significant fact that in Kansas the prescriptions per recipient decreased 10.6% from 3.65 prescriptions per recipient to 3.30 prescriptions per recipient for a similar period. The Kansas program attributed the reduction to the co-payment requirement.

Co-payment for Medicaid patients is a highly controversial issue. There can be little doubt that it has a large potential for cost containment. Yet, imposition of co-payment is counter-balanced by highly emotional arguments on behalf of the needs and condition of the indigent. Do the indigent choose not to seek medical services as a result of the additional cost requirements? Will a welfare mother avoid use of available optional services for her children because of co-payment? These are only a few of the valid questions raised in opposition to cost sharing and co-payment provisions. The choice is clearly one of public policy.

CHAPTER TWELVE - FOOTNOTES

1/ 45 CFR 249.40, Cost sharing and similar charges; or CCH, pp. 8460 through 8462.

2/ Ibid.

3/ Ibid.

4/ Ibid.

CHAPTER 13. DRUG COST CONTAINMENT

There are a number of methods available to contain the costs of supplying drugs to Medicaid recipients. One such method is the use of a drug formulary. A second method is to underwrite or insure the drug portion of the program. A third method is for the State to implement a volume drug purchasing plan. These three alternatives are described below.

A. DRUG FORMULARY

Under the present procedures in Hawaii, a physician can prescribe any drug and the pharmacist can use any chemical equivalent to fill the prescription. Pharmacist are reimbursed at 180% of cost of the drug for filling prescriptions. This provides them with an 80% gross profit margin. In view of this, the potential exists for a pharmacist to use the most expensive drug available as it will result in a higher total dollar profit.

The use of a drug formulary by the program would provide a listing of drugs that can be prescribed by the physician and must be used for filling prescriptions by pharmacists. The drug formulary is a mechanism to restrict the physician and pharmacist almost exclusively to the use of generic drugs, although all programs using the formulary approach allow physicians to specify a brand name drug when, in the physician's opinion, it is medically necessary and can be justified. Restricting the physician and pharmacist to lower cost generic drugs has a major potential of reducing the overall drug expenditures significantly without reducing or impacting the quality of care.

To determine the potential savings of implementing a drug formulary in the Hawaii program, Arthur Young & Company examined a

sample of drug transactions for recipients. It was concluded by analysis of the sample that use of a drug formulary could save the State in excess of $200,000 per year. The procedure used in the analysis relied upon translating the cost of drugs provided in the Hawaii program to the lower cost generic equivalent using another state's formulary. The findings were then extrapolated to the total program to obtain an estimate of potential savings. The estimate assumes that Hawaii would pay dispensing fees at the national average rate of $2.25 per prescription.[1/] Obviously, the potential savings would be in excess of the estimate were a lower dispensing fee used. It is further estimated that the one time implementation costs for the formulary approach would range between $50,000 - $75,000. The implementation costs, however, are eligible for 90% federal funding. This means that the State would be required to pay only 10% of the total implementation cost.

Another approach can be coupled with the drug formulary and result in additional savings. The State could adopt a reimbursement method which pays the pharmacist for the cost of a drug plus a fixed dispensing fee for each prescription filled. This would be done instead of the current approach of allowing a percentage profit on each prescription. Some states have adopted multiple reimbursement fee schedules: one fee for merely dispensing a drug and usually a higher fee for drugs which require compounding (i.e., mixing or preparing). This amount, however, cannot under any circumstance exceed the federal guidelines. The guidelines establish that the maximum that may be paid for any prescription by Medicaid is the lower of the cost of the drug plus a dispensing fee or the provider's "usual and customary" charge to the general public.

B. UNDERWRITING DRUG COSTS

A number of Medicaid programs have contracted with companies to underwrite and administer part or all of their drug programs on a prepaid, or at risk basis. The most common arrangement is one in which the contractors have agreed to administer the drug program and pay all benefits for a fixed fee. If the contractor is highly efficient in managing the program, it retains all savings. If the contractor is inefficient, it absorbs the losses. One of the states that has had a highly successful experience with a risk-basis contract for their entire drug program is Texas. North Carolina was dissatisfied with their contractor and eventually terminated this approach.

Inasmuch as the program costs are limited to the fixed amount paid the contractor, the underwriting approach is indeed a cost containment strategy requiring consideration since it offers the additional advantage of fixing costs for the period of the agreement.

C. VOLUME PURCHASING BY THE STATE

A volume drug purchasing program is in operation in California. Under a volume purchasing system, drug manufacturers bid for a contract to supply drugs for the entire recipient population. The State buys from the selected manufacturers and transfers the purchases in bulk to a wholesale firm. They in turn distribute the state purchased drugs for a fee which covers the drug storage, delivery, administrative costs, and an agreed upon profit. The drugs are then transferred to private retail or public, state-owned and operated pharmacies for dispensing at no cost to the pharmacists. The pharmacies only receive a fee for each prescription filled with the state owned drugs. California estimates that annual savings will be approximately 6 percent of their total drug costs. 2/

In fiscal 1977, the Hawaii program paid $4,756,000 for drugs.[3/] A 6% savings would be $285,00 per year.

D. RECOMMENDATIONS

It is recommended that:

1. HMSA immediately implement a drug formulary which makes extensive use of lower cost generic drugs. The program allow any program participant the opportunity to use any drug in those circumstances in which justification can be made to MCAS medical consultants.

2. Reimbursement for drugs be based on cost of the drug plus a fixed dispensing fee or usual charges, whichever is lower.

3. DSSH conduct an analysis of the costs and benefits of programs for underwriting drug costs and/or adopting a volume purchase program.

CHAPTER THIRTEEN - FOOTNOTES

1/ HMSA Special Study of Drug Dispensing Fees, 1977.

2/ National Journal, California's "Winner Take All" Plan, July 1976, p. 942.

3/ State of Hawaii, Medicaid Report 1977, p. 15.

CHAPTER 14. HEALTH MAINTENANCE ORGANIZATIONS

One alternative cost containment strategy is to attempt to provide the same services to recipients through more economical means, thereby reducing overall program costs. An organizational structure which tries to provide a package of services at a cost equal to or less than that required when the services are obtained piecemeal is the Health Maintenance Organization (HMO). Services appropriate to the needs of the individual and his or her family are planned, coordinated, and made available by the HMO through the use of HMO-employed medical staff, contractual arrangements with other providers, or a combination of these arrangements. HMO's generally provide a full spectrum of health care services including physicians, hospital, dental, laboratory, x-ray, drugs, screening services, family planning, etc. The reason HMO's may represent an economical alternative to other forms of piecemeal care is based on the method used by the HMO in charging for services. Persons served by an HMO pay a fixed monthly premium which covers all services rendered regardless of complexity or cost. Another underlying concept behind HMO's is the practice of preventive care. Unlike episodic care under insurance programs, an HMO has an incentive to include preventive health services (including family planning services, infertility services, prenatal obstetrical care, well-baby care, and periodic physical examinations) as services included in the basic cost. The HMO concept includes the potential for keeping people from using services by maintaining health because the HMO receives no additional reimbursement for excess services rendered.

Currently, Hawaii has two HMO's in operation. One of these, the Kaiser Foundation Health Plan, is currently conducting an experimental program with the Medicaid program. If the HMO experiment proves successful, the State could expand the number of recipients covered. A note of caution is necessary. In other

states, notably California, hastily conceived and administered programs of using HMO's for Medicaid recipients has lead to massive abuse and questionable cost results.

It is recommended that the experience to date with the Kaiser Foundation Health Plan HMO be formally evaluated by independent reviewers. Should the evaluation show that costs are contained while providing adequate services, a well conceived plan and operational program should be designed and implemented to allow Medicaid recipients to avail themselves of this alternative.

GLOSSARY OF TERMS

A number of specialized health care terms and acronyms are used throughout this study. They are collected and defined here to assist the reader.

AFDC	- Aid to families with dependent children, a State monitored, federally sponsored cash assistance program for needy families.
AABD	- Aid to the aged, blind or disabled individuals.
Agency, Single State	- The State agency designated to administer the Medicaid program (Department of Social Services and Housing in Hawaii).
Allowable Costs	- Those costs which are allowable by federal regulation in calculating a cost-based reimbursement rate for services.
Ambulatory Care	- Health services rendered to persons who are not confined overnight in a health care institution (also referred to as "outpatient services").
Ancillary Services	- Diagnostic or therapeutic services performed by specific hospital departments (such as labatories) as distinguished from general or routine patient care (such as room and board).

Audit Programs - Guidelines or procedural requirements used for conducting examination of financial or other records.

Biological - Drugs affecting the physiology through biological means.

Buy-in - The process by which the Medicaid program pays the Medicare co-insurance premium amount for a recipient thus having the Medicare program incur the cost of some health care services.

Buy-in Agreement - A formal written agreement with DHEW allowing the State to enroll Medicaid-eligible recipients in the Medicare program.

Capitation - (a) the common term applied to the arrangement in which a patient enrolls in a health care institution and agrees to pay a periodic fixed rate for a specified set of services, regardless of whether or not he uses such services; (b) fixed charge, assessed per capita or per family unit for enrollment in a membership plan which provides health care services on a prepaid basis (such as a Health Maintenance Organization).

Cash Assistance Programs - Those public welfare programs which distribute benefits to recipients in the form of cash payments (included are AFDC, general assistance, SSI, etc.); excluded are employment services, food stamps, counseling, etc.

Categorically Needy - Those recipients who are eligible for Medicaid services due to their eligibility for a cash assistance public welfare program (such as AFDC, supplemental security income, State supplementary payments under SSI, etc.).

Certification - The process of determining eligibility of an applicant for public assistance; and the process of approving a provider and provider's physical facilities as being capable of rendering assistance.

Claims - Method by which vendors request payment from the Program.

Co-insurance - An enrollment fee or premium charge paid by recipient.

Concurrent - Accomplished during the face (such as concurrent review when the necessity of patient admission is reviewed at the time of admission).

Cost-Sharing - Arrangement whereby recipient pays a portion of the expenses incurred for health care.

Customary Charges - The amount typically charged the average patient for a particular service rendered.

DSSH - Department of Social Services and Housing.

Diagnostic Services - Medical procedures or supplies required to identify the existence, nature or extent of illness, injury or other health deviation.

Drug Formulary - Listing of pharmaceutical substances for which the program will reimburse the provider at a specified amount once dispensed to the recipient.

EPSDT - Early and period screening, diagnosis and treatment program restricted to persons under 22 the purpose of which is to detect (and refer for treatment) health abnormalities in children.

Enrollment Fees - Amount charged recipients, as a premium, entitling them to coverage of the program.

Extended Care Facilities (ECF)	- See skilled nursing or intermediate care facilities.
Factoring	- Reassignment of claims, usually at a discounted rate, enabling the provider to collect instantly on the claim and causing the program to pay the factors rater than the provider.
Family Planning	- Counseling, supplies and procedures rendered to persons of child-bearing age that are directed toward planned family growth.
FFP - Federal Financial Participation	- Funds provided to the program from the federal government.
Fee Schedule	- Listing of acceptable fees or established allowances for specified medical procedures. Usually represents the maximum amounts that a program will pay for specified procedures.
Fiscal Agent	- Contractor that processes and pays vendor claims on behalf of the state medicaid agency.
Fiscal Intermediary	- See fiscal agent.
Formulary	- See drug formulary.
General Assistance Recipients	- Those individuals receiving State supplementary income and for which the federal government will not share in the cost of Medicaid coverage.
Generic Drugs (non-proprietary drugs)	- The established chemical equivalent of "brand name" drugs which gives the same therapeutic effect as the brand-name drug.
HMSA	- Hawaii Medical Service Association.
HMO - Health Maintenance Organization	- Legal entity which provides health services to enrolled individuals on a prepaid capitation risk basis (normally a fixed monthly fee) using a clinic or prescribed list of providers that an enrollee may consult at no extra charge for health care services.

Home Health Agency	- Entity which supplies nursing care, supplies, appliances, equipment under the orders of a physician in the recipient's place of residence.
IFC - Intermediate Care Facilities	- Institution which provides nursing care on an intermediate basis (lower level of care than a skilled nursing facility or hospital and above the level of room and board).
Long-Term Care Facilities	- See intermediate care facilities and skilled nursing facilities.
Medical Review	- See utilization review.
Medically-Needy	- Individuals whose income and resources are too high to qualify as categorically-needy but who, in view of the State, cannot afford to pay their medical bills.
MMIS - Medicaid Management Information	- Model computer system used to pay vendors and generate related information and control reports.
Medicare	- A third-party reimbursement program administered by the Social Security Administration that underwrites the medical costs of persons 65 and over and some qualified persons under 65. "Part A" covers hospital services and "Part B" covers physicians' services.
Nursing Homes	- See intermediate care facilities and skilled nursing facilities.
Patient Day	- Unit of output denoting lodging provided and services rendered to an inpatient for one full day.
Participant	- Individual or group practitioner (doctors, dentists, etc.) who provide health care services.
Plan of Care	- Written plan which sets forth reasonable goals or behaviorally-stated objectives and prescribing a program of activities, experiences or therapies necessary to obtain optimal patient functioning.

Provider	- Institution health care vendor such as nursing homes, and hospitals.
Prior Authorization	- Approval given before the fact by an authorized agent allowing the provider to proceed with a specified plan of care.
PSRO - Professional Standards Review Organization	- A body responsible for evaluating the appropriateness of medical determinations (diagnosis and length of stay) so payments will be made only for medically necessary services in accordance with professional standards.
Prospective	- Accomplished before the fact (such as prospective reimbursement rates which are set in advance of actually providing services or incurring related costs).
Prospective Reimbursement	- Rates of reimbursement set in advance of rendering service (also known as prospective payment).
Recertification	- Review of eligible recipient, provider or institution according to established criteria to determine if eligibility should continue.
Retrospective Reimbursement	- Determination of the rate of reimbursement after services are rendered.
Screen	- A standard condition (or value) against which data is compared to determine similarity (or lack thereof).
Single State Agency	- State agency (or subdivision thereof) responsible for administering the Medicaid program.
SNF - Skilled Nursing Facility	- Institution which provides continuous nursing services to residents on a 24-hour basis.
State Plan	- Document which specified all component elements of the State's Medicaid program including covered recipients, services, vendors, reimbursement methodologies, etc.

SSI - Supplemental Security Income	- Cash assistance provided to aged, blind or disabled.
TPL - Third Party Liability	- Insurance or other coverage from sources outside of the program.
Usual and Customary	- A means of which to base reimbursement rates for participants. Usual and customary typically refers to the amount which the individual practitioner usually and most frequently charges his patients for a specific service in similar medical circumstances. Thus a usual and customary charge is a charge that is in line with both the prevailing charge in the community and what the participant charges other categories of patients.
Utilization Review	- Program to safeguard against inappropriate delivery of medical care and services, excess payments and low quality of service through continuous review of actual medical records and claims data against prescribed standards.
Vendor	- Provider of health care services (such as hospital, doctor, dentist, etc.).

SUMMARY OF FEDERAL LEGISLATION

The overall governing law of the Medicaid program is the Social Security Act of 1935. The following represents an overview of the amendments to that law.

1. 1971 - Public Law 92-223 allowed states the option of including intermediate care facilities (ICF) in their Medicaid programs. Prior to 1971, ICF services provided by the states were not eligible for FFP.

2. 1972 - Public Law 92-603 substantially amended the Federal Medicaid law. The amendments included strengthening eligibility determination matters, required that certain services be offered by the participating states, placed reimbursement limitations on certain services, allowed for pre-payment arrangements, imposed penalties for noncompliance by the states, placed controls on the delivery of service and quality of service delivered, set minimum standards for providers' participation, provided for cost sharing by recipients, specified penalties for fraudulent acts, and mandated numerous other similar program changes. In essence, the amendments were another significant step in forcing state compliance to Federal directives, thereby removing even more latitude from the state.

3. 1973 - Public Law 93-66 amended the Federal Medicaid law mainly to clarify the Medicaid eligibility of needy aged, blind, and disabled persons in relation to their eligibility under the Federal supplemental security income (SSI) program. More importantly, P.L. 93-66 required states to supplement Federal SSI payments for aged, blind and disabled persons.

4. 1973 - Public Law 93-233 made additional eligiblity determination modifications to the Medicaid law. The most notable change was the requirement that states cover certain groups of welfare recipients that heretofore had not been covered. This added an additional financial burden on the states.

5. 1974 - Public Law 93-368 provided for, among other things, the optional imposition of an enrollment fee, premium or similar charge on medically-needy persons. The fee had previously been mandatory.

6. 1975 - Public Law 94-182 modified the Medicaid law in a number of ways including requiring states to consent to suits by providers. This law allowed the Federal government to reduce a state's share of federal Medicaid funds by 10% for lack of compliance in this area. The law also allowed utilization review or screening of each inpatient admission on a sample basis.

7. 1977 - Public Law 95-142 is the most recent change to the Medicaid law, having been signed into law in October. The law is designed primarily to strengthen control over fraud and abuse in the program. However, the provisions also cover other areas. For instance, the role of the Professional Standards Review Organization (PSRO) is clarified incentives for collection of outstanding liabilities are provided, funding levels for investigation activities are significantly increased, and certain penalties for noncompliance are specified.

The above represent the key amendments to the Social Security Act as it relates to the Medicaid program. Suffice it to say, that the amendments have typically imposed a greater degree of federal control over the program, thereby reducing the flexibility of the states over the direction of their Medicaid program.

SELECTED CHANGES IN MEDICAID SERVICE BY STATE
January 1, 1975 – March 31, 1977

STATE	CHANGES IN SERVICES	ELIMINATION OF SERVICES	IMPLEMENTATION OF COPAYMENT
Alabama	–Hospitalization, general, TB and AFDC psych. patients: reduced inpatient days from 30 to 20 per year without preauthorization.–Physicians' visits for chronic stable illnesses outside hospital limited to one per month.–Physicians' visits for hospital confined patients limited to one per day.–Nursing Home Services ceiling on reimbursement to SNF's of $21.50/day; to ICF's of $19.35/day. Home Health Care requires preauthorization and $25 per visit ceiling. Limited to 100 visits per calendar year, with some limitations.–Medical Supplies, Equipment and Appliances: Limited to basic published list.–Personal Needs Allowance for aged, blind, and disabled nursing home recipients reduced from $48 avg./mo. to $25 mo.	–Eliminated telephone consultation by physicians.–Eliminated inpatient psychiatric hospital services for individuals under 22.–Eliminated reservation of bed in nursing home while patient is hospitalized.	–Prescription drugs – copayment of .50 per prescription and refill (based on an average payment by the State of an amount less than $10).
Alaska	–Hospital, Nursing Home and Mental Hospital Service coverage added for individuals in medical or ICF whose income while in facility does not exceed 300% of SSI benefit rate but who would not be eligible for optional State supplement if they left facility.–Optometric Services: optometric services, eyeglasses added for individuals with speech and hearing difficulties.	–Eliminated coverage of unborn children.	
Arkansas	–Drugs: Recipients limited to three prescriptions per month.		–Prescription drugs – copayment of .50 per prescription, including patients in institutions.
California		–Eliminated optional group (relatives who care for child(ren) under 21 except those eligible for AFDC).	
Connecticut	–Mental hospitals and nursing homes: new cost reimbursement formula implemented. Nursing home services extended to 2 visits monthly without prior authorization.–Mental retardation services extended from 3 months to a calendar year.		
D.C.	See end of chart.		
Delaware	–Added inpatient psychiatric hospital services for individuals under 21.		

Florida	–Drugs limited to $20 per month per recipient. Hospitalization Services: inpatient hospital days reduced from 45 to 30 per year; outpatient hospital services limited to $50 per year without pre-authorization.–Escalation factor reduced from 9% to 6% per diem. Dental Services reduced under EPSDT to minimum required under Federal regulations.–Physicians' Services – following ceilings on payment implement: 1) initial office visit: $15, 2) Follow-up office visit: $10, 3) Hospital admission visit: $20, 4) Hospital admission follow-up visit: $10, 5) Initial nursing home visit: $20, 6) Follow-up nursing home visit: $10, 7) Emergency room visit: $15, 8) Consultation – limited report: $20, 9) Consultation – history and physical plus report: $35, 10) Office visit and hospital admission visit same day: $25, 11) $312 per person for psychiatric services per year.–Eye examination ceiling on payment under EPSDT reduced from $20 to $15.–Dental Services: limited under EPSDT to $125 per individual without prior authorization.–Nursing Home Services maximum payment for SNF services reduced from $600 to $585/month.–Level of care changed from skilled to intermediate, payment is made at higher rate for only 30 days.–Nursing Home Care extended from Skilled and Intermediate I and Intermediate II. Children's Medical Services established as provider of screening services in pilot project, to be implemented shortly statewide.–Mental Retardation: Implemented on 3 levels of payment dependent on retardation level and behavior pattern of individual.–Transportation: $22.50 established as maximum for ambulances. Limitation by providers of that service established.–Physician Services: all-inclusive fee established for certain types of visitors and limitations for elective surgery established.–Hospital Services: payment for inpatient and outpatient services reduced.		
Georgia	–Physicians' services limited to: 1) One home, office, outpatient hospital or nursing home visit/month with exceptions allowed for medical necessity, 2) One inpatient hospital visit per day with exceptions allowed for medical necessity.–Nursing Home reimbursement changed from Georgia formula to Title XVIII formula. SNF rate changed from 105% to 102%. Does not include ICF coverage.	–Eliminated allowance for non-covered medical expenses for personal needs allowance for aged, blind and disabled recipients.–Eliminated dental services and dentures (adult).–Eliminated eyeglasses, optical services and contact lens.–Eliminated psych. inpatient care for individuals 65 or older.	–Prescription drugs – copayment of $.50 per prescription. Copayments also imposed on ambulance services, durable medical equipment, and orthotic/prosthetic services. Imposed copayment on physician, outpatient hospital and inpatient hospital services under 1115 waiver.
Idaho	Abortion services will not be provided unless related services are recommended by 2 physicians who indicate abortion is necessary to save life or health of mother, or is result of rape or incest determined by courts.		
Illinois	Froze SNF and ICF rates.		

Kansas			–Prescription drugs – copayment of $.50 per prescription.
Kentucky		–Eliminated coverage for: 1) individuals who are eligible but not applied for AFDC or SSI coverage or optional State Supplementary Benefits, 2) inpatient individuals who would be eligible for AFDC or SSI if they left the facility, 3) eligible inpatients who would be ineligible if out of facility.	
Louisiana	–Outpatient physicians' visits limited to 12 per year with extensions allowed for medical necessity.–Inpatient physicians' visits limited to 15 per year when recipient is hospitalized without surgery.	–Additional payment to physicians for injectible medications was eliminated.–Eliminated non-legend drugs except for insulin, calcium, iron and nicotinic acid.	–Prescription drugs – copayment of $.50 per prescription.
Maine		–Eliminated day treatment from mental health clinic services.–Eliminated private rooms in hospitals.–Eliminated private duty nursing.–Eliminated coverage of unborn children.	–Drugs – copayment of $.50 per prescription.
Maryland	–Limited adults to one eye examination and one pair of eyeglasses every two years.–Limited children to one examination and one pair of eyeglasses every year.–Limited durable medical equipment to those items recognized by Title XVIII.–Cost containment: implemented in dentistry, podiatry, transportation and medical equipment.–Pharmacy: introduced a cost list for legend drugs.	–Eliminated dental care.–Eliminated non-legend drugs except for insulin, needles, syringes and contraceptives.–Eliminated payment for hospital inpatient "medical-social days."–Eliminated routine foot care except for recipients who are diabetic or have vascular disease.–Eliminated custom foot supports.–Eliminated all disposable medical supplies except for ostomy supplies and supplies for permanent urinary incontinence.–Eliminated repair and replacement of broken eyeglasses.	–Drugs – copayment of $.50 per prescription.
Massachusetts	–Restricted podiatry to prevention and treatment of disease.–Restricted optometrists services by excluding absorptive lenses of greater than 25% absorption, prisms obtained by decentration and treatment of congenital dyslexia.–Restricted both legend and nonlegend drugs.	–Eliminated chiropractors' services.–Eliminated dental services.–Eliminated private duty nursing in hospitals.–Eliminated hearing aids for adults.	

Michigan	–Psychiatric Care: Recertification required by Dir. Dept. Mental Health on 12–118 days and every 30 days thereafter. MA Recipients – protected income level reduced from 110% to 100% of PA standards. Maximum fee screens reduced by 4% for: 1) ambulance providers, 2) Community Mental Health Services Board Clinics, 3) Dentists and Dental Clinics, 4) Laboratories, 5) Practitioners, 6) Vision Providers. HMO's Capitation Rates: Reduced 4% Nursing Homes: 1) Not certified as Medicare providers but providing skilled care for Medicare – eligible recipients paid only coinsurance amount for Medicare coverage, 2) Ceiling rates established: SNF – $23.75, ICF $21.90 (one level of ICF). Early and Preadmission Testing implemented for elective procedures. U/R Evaluation: Inpatient hospital stays. Laboratory Providers: Paid on scale for automated rates. Vision Care: Reexamination every 2 years for those under 21 and 3 for adult population. Glasses replaced every 3 years. Dental Care: Dental care under 21, emergency care for adults. Replacement of dentures every 5 years.	–Eliminated in nursing homes: 1) physical, 2) occupational, 3) speech therapy, 4) legend drugs, except insulin.	–Drugs: copayment of $.50 per prescription. Optometrics $3 per vision visit. Dental $2 per emergency visit and other visits except for dentures which functionally operate.
Minnesota	–Limitations: certain services without prior authorization.		
Mississippi	–Two classes of drugs in all perepheral vasodilators taken off formulary except nicotinic acid. Anti-arthritic drugs taken off formulary except aspirin and Tylenol. Prescription refills limited to 5 in number unless otherwise specified.–SNF Rate increased from $17.90 to $19 per day; ICF Rate increased from $16.10 to $17 per day; EPSTD: maximum cost increased from $17 to $19 per child.		–Prescription drugs – copayment of $.50 per prescription.
Missouri	–Visual training added.–Hospitalization: Limitation on number of days removed.–Drugs: Limitation on maximum dollar coverage removed.		
Montana			–Prescription drugs – copayment of $.50 over two prescriptions monthly except for institutionalized persons.
Nevada	–Physician care limited to not more than two adult office or nursing home visits and two therapeutic injections per month.–Podiatry limited to emergency care.–Dental care limited to emergency care.–Dental care limited to emergency care.–Prescriptions limited to 3 per person per month and only emergency refills. Dispensing fee increased to $2.75.	–Eliminated coverage of care in mental and TB hospitals, services of psychologists, claims already paid by recipient, third party, or county.	–Prescription drugs – copayment of $.50 per prescription cost of $25 or less, $1 for those costing $25.01 to $50, $3 for those costing $50.01 or more.

New Hampshire	–ICF Care: 1) decrease in cost allowance, 2) reduced payment from 95% to 90% of allowable cost.–Added community health centers and family planning agencies.	–Eliminated adult dental services except for emergency care.	
New Jersey	–Reduced dispensing fees to pharmacies by $.25.–Reduced reimbursement to practitioners, prosthetic and orthotic suppliers, medical supplies, hearing aid dealers, and transportation providers by 10%.–Reduced reimbursement for lab services by 40%. –Extended minimum period for replacement of dentures from 3 to 5 years.–Instituted limited drug formulary.	–Eliminated non-legend drugs except for insulin and contraceptives.–Eliminated dental services and dentures.–Eliminated optometry services and eyeglasses.–Eliminated podiatry services.–Eliminated medical supplies.–Eliminated hearing aids.–Eliminated psychological care.–Replacement of lost or broken eyeglasses no longer reimbursed.	–Imposed $.25 copayment per prescription.
New Mexico	–Pharmacy: Upper limits established for medications, medical supplies and Durable Sickroom Program.–Long Term Care: 1) Income standards for persons in need increased from $290 to $305 monthly, 2) specific management and accountability required of personal funds of patients.–Pharmacy: Dispensing fee increased from $2 to $2.50.	–Eliminated Renal Dialysis: suspended indefinitely.	
New York	–Hospital: Payment limitations for in-hospital care.–Deferred surgery and second opinions implemented.–Payment of reasonable charges for prescribed drugs: coverage and reimbursement for selected non-prescription drugs. Interns and residents' salary plan approved amending 10% reduction for inpatient reimbursement.		
North Carolina		–Eliminated coverage of unborn children.	–Legend drugs and insulin – $.50 per prescription; optical supplies and services $2 per visit. Medically Needy Hospital Outpatient Day Visit: $1, Hospital Inpatient Day: $2, Office Visit: $1, Home Visit: $1, Radiology: $1, Drugs & Prescriptions: $.50, Chiropractic Services: $1, Dental Services: $2.
North Dakota	–Institutional Care: cost sharing for personal and selected non-covered services, mainly dental, applied to medically needy.		–Prescription Drugs: copayment of $.50 per prescription except for family planning drugs. –Eyeglasses: copayments for adults of $2 per paid and $.50 for replacement or repair of parts.

Ohio	–Hospital Care: 1) not to be used as alternate for Home Health or Nursing Home Care, 2) Payment for day prior to surgery allowable when documented by U/R committee.–Physician Visits: Limited to 10 per month.	–Eliminated: legend drugs except insulin and family planning supplies, Durable Medical supplies except oxygen equipment.–Eliminated Nursing home coverage during hospital stay.–R.N. Care, Physical Therapy, Chiropractic Services, Occupational Therapy, Podiatry: only when medically necessary.	
Oklahoma	–Personal allowances: for ICF patients reduced from $65 to $50 per month.	–Eliminated coverage of families with unemployed fathers.	
Pennsylvania	–Pharmaceuticals: 1) Index of compensable over-the-counter drugs released, 2) Family planning drugs and intrauterine devices extended to medically needy, 3) program established to identify "overutilization of drugs". Required to use single pharmacy for future services.–Eligibility Form: New type implemented. Hospitals: Claims payments changed from semi-monthly to weekly basis.–Out-of-state recipients: Entitled to care in emergency situation if services are postponed; and health endangered if travel home undertaken,–Psychiatric Clinic Services: Available to all MA recipients with no limitations,–Facilities: Required to have medical director responsible for supervision of medical care and services provided.–Reimbursement for non-therapeutic abortion: Includes Rh immunization globen, for RN–negative patients. New Medicaid Eligibility Cards Issued: Issued Monthly on 16th eligible thru 15th of following month for categorically needy. Color coded for levels of recipient need-medically needy issued cards quarterly.–SNF and ICF: Cost related reimbursement implemented, Transportation: Increased from $.07 to $.12 per mile. Reimbursement rate for ambulance services increased from $.70 to $1.00 per mile, increase of $15 to $20 per trip.		
South Carolina	–Subsidized Adoptions coverage discontinued.–Eye Care: Added eye retractions under optometrist services for recipients over 21.		–Prescription drugs – copayment of $.50 per prescription.
South Dakota		–Eliminated Eye-refraction and glasses for adult population, Chiropractic and podiatric services–Eliminated non-legend drugs except for insulin.	–Prescription drugs – copayment of $.50 per prescription.

Tennessee	–ICF Room Rent: Reimbursement increased from $17 to $21 per day maximum or cost whichever is less.–Mental Retardation: reimbursement changed to $30 per day or charges whichever are lower.–Limited antibiotics and bacteriostatics and certain combination drugs to those listed in the pharmacy manual.	–Eliminated the following types of physician services: 1) Manipulation therapy that is necessary to set a fracture or dislocation, 2) Electrical muscle stimulation as therapy. Nerve condition tests are covered when used for diagnostic purposes, 3) Physical therapy by use of mechanical apparatus when used internally in the vagina or rectum. This does not exclude prostatic massage or diagnostic procedures such as diagnostic proctoscopic or sigmoidscopic examinations, 4) Injection of trigger points or nerve blocks except for diagnostic purposes or temporary local anesthesia.–Eliminated dermotological preparations including vaginal preparations for douche solutions.	
Texas	–Dentistry: Payment of removable partial and/or full dentures for recipients 21 years or over.–Hearing Preliminary evaluation and dispensing of hearing aids with specified follow-up visits and repairs allowed.	–Eliminated psychiatric care for persons age 65 or older in mental hospitals.	
Virginia	–Limited inpatient hospital coverage to 14 days. Coverage may be extended up to 21 days for certain admissions based on medical necessity.	–Eliminated non-legend drugs except for insulin syringes and needles and all family planning supplies.–Eliminated anorexants and propxyphene drugs.–Eliminated $1.50 growth and development factor from nursing home payments.	–Prescriptions: drugs–copayment of $.50 per prescription and refills dispensed on outpatient basis; eyeglasses–copayment of $2 for each pair, and for repair or replacement of parts costing more than $5.
Washington	–Prosthetic devices added.		
Wyoming	–Prosthetic devices added.		
* District of Columbia	Prescriptions only selected non-legend drugs can be covered by the program, e.g., pain relievers ingested orally, stomach acid relievers, diabetes preparations, family planning supplies, vitamins (for children under seven years of age and pregnant women), formularies especially prepared for the elderly.–Eyeglasses limited to one pair every 24 months. If recipient breaks or loses same within that period, charges for replacement are recipient's responsibility. –Orthopedic shoes – only shoes attached to braces are allowed. AFDC participants not in above group are diagnosed and prescribed at D.C. General Hospital. Those over 21 and have hospitalized shoes will be described in same manner as adults.		–Prescriptions: $.50 copayment implemented for legend and specified non-legend.–Eyeglasses $2.00 per pair.

Source: Division of Program Monitoring, Social and Rehabilitation Service, U.S. Department HEW and Departments of Health and Social Services in various states of the U.S. and Medicaid Management Study Team, Department of Health and Social Services, Madison, Wisconsin.

STRUCTURE OF THE WASHINGTON STATE RATE REVIEW COMMISSION[1]/

Five members known of as "Commissioners" appointed by the governor and confirmed by the Senate, generally representative of consumers, labor, business and hospitals. Four-year terms; no compensation; expenses only.

TECHNICAL ADVISORY COMMITTEE

Appointed by the governor, four-year terms; no compensation; expenses only. Membership includes: One certified public accountant knowledgeable in the financial affairs of hospitals; one health care practitioner knowledgeable in hospital administration; five persons to represent hospitals; one representative of consumers; the Secretary of the State Department of Social and Health Services or his designee; the Director of the State Planning and Community Affairs Agency or his designee; and one of the commissioners.

The Technical Advisory Committee has the duty, upon request of the Commission, to consult and make recommendations to the Commission on matters of policy, rules and regulations proposed by the Commission, analyses and studies of hospital costs and other matters which the Commission may refer.

STAFF

Full-time executive director and a deputy director appointed by the Commission.

Additional staff, as needed, from the Department of Social and Health Services. The Commission may also employ consultants.

FUNDING

Expenses of the Commission will be financed by an assessment against hospitals in an amount to be determined biennially by the Commission, but not to exceed four one-hundredths of one percent of each hospital's gross operating costs.

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1. Based on the structure of the Washington State Hospital Commission as described in "Methods of 'Containing' Medicaid Costs", Ohio Legislative Budget Office, Informational Memorandum No. 35, April 1976.

STRUCTURE OF THE WASHINGTON STATE RATE REVIEW COMMISSION

DUTIES

(1) Establishment of uniform accounting and financial reporting for hospitals, effective not later than two and one-half years from the date of formation of the Commission. The Commission must consider the existing systems of accounting and reporting presently used by hospitals, differences between hospitals according to size, financial structure, methods of providing services and other distinguishing factors.

The accounting system, where appropriate, must be structured so as to establish and differentiate costs incurred for patient-related services rendered by hospitals, as distinguished from those incurred with references to educational, research and other nonpatient-related activities.

(2) Make analyses and studies relating to hospital health care costs and the financial status of hospitals.

(3) From a date not less than 12 months or more than 24 months after the adoption of uniform accounting and financial reporting, rate review by the Commission will be started to assure purchasers of hospital services that the total costs of a hospital are reasonably related to the hospital's aggregate costs, and that rates are set equitably among all purchasers or classes of purchasers of services without undue discrimination or preference.

(4) In the interest of promoting the most efficient and effective use of hospital health care service, the Commission may promote and approve alternate methods of rate determination and payment of an experimental nature that may be in the public interest.

(5) The Commission will require the filing of information concerning the total financial needs of each hospital and the resources available or expected to become available to meet needs, including the effect of proposals made by area-wide and state comprehensive health planning agencies.