



REPORT TO THE CONGRESS

Improved Controls Needed
Over Extent Of Care Provided
By Hospitals
And Other Facilities
To Medicare Patients B-164031(4)

Social Security Administration
Department of Health, Education,
and Welfare

*BY THE COMPTROLLER GENERAL
OF THE UNITED STATES*

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COMPTROLLER GENERAL OF THE UNITED STATES

WASHINGTON, D.C. 20548

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To the President of the Senate and the
Speaker of the House of Representatives

This is our report on improved controls needed over the extent of care provided by hospitals and other facilities to Medicare patients. This program is authorized by title XVIII of the Social Security Act (42 U.S.C. 1395) and is administered by the Social Security Administration, Department of Health, Education, and Welfare.

Our review was made pursuant to the Budget and Accounting Act, 1921 (31 U.S.C. 53), and the Accounting and Auditing Act of 1950 (31 U.S.C. 67).

Copies of this report are being sent to the Director, Office of Management and Budget, and to the Secretary of Health, Education, and Welfare.

A handwritten signature in cursive script, reading "James B. Argets".

Comptroller General
of the United States

D I G E S T

WHY THE REVIEW WAS MADE

Because of congressional concern about rising Medicare costs, the General Accounting Office (GAO) reviewed the effectiveness of procedures established to control the extent of care provided to Medicare patients in hospitals and extended-care facilities. This review was made at 41 hospitals and 49 extended-care facilities in five States.

Medicare payments for care provided by hospitals and extended-care facilities increased from \$2.5 billion in fiscal year 1967 to \$4.7 billion in fiscal year 1970.

The potential significance of controls over the utilization of medical services is illustrated by a statement of a former Secretary of the Department of Health, Education, and Welfare (HEW), in which he estimated that Medicare costs could be reduced by as much as \$400 million annually if each Medicare patient's hospital stay could be reduced by a single day.

GAO was assisted in its evaluation by consulting physicians, some of whom were employed by the Social Security Administration (SSA) or its fiscal intermediaries and others who represented State medical societies.

Program description

Eligible persons aged 65 or over are provided with protection against most of the costs of care provided (1) by hospitals during acute stages of illness and (2) by extended-care facilities when skilled nursing care is required on a continuous basis for a condition previously treated more intensively in a hospital.

SSA has primary responsibility for administering the Medicare program for HEW. In turn, HEW has contracted with (1) private organizations, called fiscal intermediaries, to assist SSA in reviewing and paying benefit claims and (2) the States, to determine the eligibility of facilities to participate in the program.

Legislative history shows that the Congress was concerned that Medicare provide necessary care to the patients but that patients remain in the hospitals or extended-care facilities only as long as necessary.

To control the extent and cost of care provided, the Medicare legislation stipulated that hospitals and extended-care facilities institute certain procedures designed to discourage unnecessary utilization of medical services and facilities.

The Medicare law requires that each hospital and extended-care facility participating in the program establish a utilization review committee, consisting of at least two physicians, to review the medical necessity of admissions, duration of stays, and professional services rendered.

The Medicare law provides also that, for a patient's stay in a hospital or an extended-care facility to qualify for Medicare coverage, his attending physician must certify, and periodically recertify, that the stay is medically necessary.

FINDINGS AND CONCLUSIONS

GAO found that the review committees helped, to some extent, to reduce unnecessary costs which would otherwise have been borne by the Medicare program. (See p. 17.)

GAO also found, however, that efforts of SSA and the intermediaries had not resulted in a full understanding, on the part of review committees, of the limitations on the type of care which could be provided and paid for under the Medicare program. (See pp. 17 to 21.)

GAO's consulting physicians reviewed the same records--for 1,735 Medicare patients--which had been available for examination by the review committees. In 465 cases the consulting physicians questioned whether the care provided should have been paid for under the Medicare program.

The questions raised by GAO consulting physicians generally centered around the following issues:

- Whether a hospital patient's condition required hospital care or skilled nursing care in an extended-care facility.
- Whether an extended-care-facility patient's condition required continuous skilled nursing care or merely custodial care.
- Whether the care needed by a patient in an extended-care facility or a hospital could be provided on an outpatient basis.

These issues are ones on which professional judgments may differ. Therefore GAO is not in a position to say how many patients should or should not have received certain levels of care. These differences in

professional judgment, however, point up a number of significant problem areas which require the further attention of SSA in its efforts to achieve an effective utilization review function as part of the controls exercised over the Medicare program.

GAO believes that an understanding by the review committees of the levels of care which can be covered by Medicare is important so that the committees' consideration of cases can be of maximum assistance to the intermediaries in their determinations of whether the cost of the care should be paid for under the Medicare program.

GAO found other important problems in the manner in which hospitals and extended-care facilities had implemented the requirements for utilization review and physicians' certifications and in the controls being exercised over these functions by SSA, fiscal intermediaries, and State agencies. (See pp. 22 to 35.)

A need exists for SSA to develop clearer and more definite guidelines pertaining to the responsibilities of State agencies and intermediaries, to ensure compliance with the legislative requirements for utilization reviews and physicians' certifications. SSA also should expand its reviews of State agency activities, to obtain greater assurance that these agencies are enforcing compliance by hospitals and extended-care facilities with their approved utilization review plans.

By SSA's taking actions to improve the carrying out of the utilization review function and to enforce more effectively the legislative requirements of the Medicare program, fiscal intermediaries would be in a better position to identify, on a timely basis, cases involving noncovered care to patients under the Medicare program. Such actions may also significantly reduce the Medicare costs. These actions will also reduce the incidence of retroactive denials of benefit payments which occur when intermediaries discover that noncovered care has been provided.

RECOMMENDATIONS AND SUGGESTIONS

The Secretary of HEW should arrange for SSA to take the following actions.

- Define more clearly the role of the utilization review committees, to make clear that their decisions are essential to the intermediaries in determining whether the care provided to patients in hospitals and extended-care facilities is covered under the Medicare program.
- Define the responsibilities of State agencies and intermediaries more clearly with respect to (1) monitoring follow-through actions taken on the questions raised by review committees and (2) ensuring compliance with the legislative requirements regarding review

committees' activities and physicians' certifications and recertifications of the necessity for continued care.

- Establish more appropriate criteria for determining when cases involving stays in hospitals and extended-care facilities should be reviewed by review committees.
- Provide for increased attention, in SSA's reviews, to whether State agencies are doing an adequate job of determining the degree of compliance by hospitals and extended-care facilities with their approved review plans. (See pp. 37 and 38.)

AGENCY ACTIONS AND UNRESOLVED ISSUES

HEW agreed that there was a need for SSA, State agencies, and intermediaries to take additional practical measures to foster the role of review committees as set out in the law. HEW outlined several actions which it had taken or proposed to take to improve the utilization review function. (See pp. 37 and 38 and App. I.)

HEW officials estimated that, as a result of such actions, Medicare costs in fiscal year 1972 would be reduced by about \$60 million.

MATTERS FOR CONSIDERATION BY THE CONGRESS

This report is furnished because of interest expressed by committees and members of the Congress in the Government's efforts to provide quality medical care to the aged and, at the same time, to curb unnecessary use of institutional care and services under the Medicare program.

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ABBREVIATIONS

- ECF extended-care facility
- GAO General Accounting Office
- HEW Department of Health, Education, and Welfare
- SSA Social Security Administration

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CHAPTER 1

INTRODUCTION

Title XVIII of the Social Security Act (42 U.S.C. 1395), enacted on July 30, 1965, established the Medicare program which is administered by the Social Security Administration, Department of Health, Education, and Welfare. The program provides eligible persons (beneficiaries) aged 65 or over with two basic forms of protection against the costs of health care services.

One form, designated as Hospital Insurance Benefits for the Aged (part A), covers inpatient hospital services and post-hospital care in extended-care facilities (ECFs) and in patients' homes. Coverage under this act became effective on July 1, 1966, for care provided by hospitals and on January 1, 1967, for care provided by ECFs. Benefits paid under part A of the program are financed by special social security taxes collected from employees, employers, and self-employed persons.

Over 20 million people are covered under part A of the program. During fiscal year 1970 about 7,000 hospitals participated in the Medicare program and were reimbursed for costs amounting to about \$4.4 billion; about 5,800 ECFs participated in the program and received payments totaling \$295 million.

The second form of protection, designated as the Supplementary Medical Insurance Benefits for the Aged (part B), is a voluntary program and covers physicians' services and a number of other medical and health benefits, including hospital outpatient services and certain home care. Benefits paid under part B of the program are financed from (1) premiums collected from eligible beneficiaries and (2) matching amounts appropriated from the general revenues of the Federal Government.

This report is concerned with the controls over the extent of care provided to Medicare patients by hospitals and ECFs under part A of the program. Pursuant to the Social Security Act, the Secretary of HEW entered into agreements (1) with public and private organizations and agencies to

act as fiscal intermediaries in the administration of benefits under part A of the program and (2) with States, to determine the eligibility of hospitals and ECFs to participate in the program.

Part A of the program provides for eligible beneficiaries to receive hospital care when such care is medically necessary. Extended-care benefits are provided for when the patient requires skilled nursing care on a continuous basis for a condition related to a previous hospital stay. A patient is eligible to receive extended-care benefits if he enters an ECF within 14 days following his discharge from a hospital in which he was confined for at least 3 consecutive days.

The Congress intended that hospital care would be provided and paid for under Medicare during the acute stages of the patient's condition and that less expensive extended care would be provided during the period of recovery in which the patient's condition was less acute and did not require care as intensive as that available in hospitals.

The concept of extended care, as defined in the Medicare law, differs from custodial care of the type traditionally provided by nursing homes, which is expressly excluded by law from coverage under the Medicare program. The Congress intended that the program would cover only high-quality convalescent and rehabilitative care in an ECF, where medically appropriate, as an alternative to inpatient hospital care. An ECF is defined in the law as an institution which, in addition to meeting certain other requirements, is engaged primarily in providing skilled nursing care and related services to patients who require medical or nursing care or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

In its instructions to Medicare intermediaries, SSA has described "continuous skilled nursing care" in the following manner:

"Skilled nursing care includes components which distinguish it from supportive care which does not require professional health training. One component is the observation and assessment of the

total needs of the patient. Another component is the planning, organization and management of a treatment plan involving multiple services where specialized health care knowledge must be applied in order to attain the desired result. An additional component is the rendering of direct services to a patient where the ability to provide the services requires specialized training.

"In evaluating whether the services required by the patient are the continuous skilled services which constitute 'extended care,' several basic principles must be kept in mind:

- "1. Since extended care represents skilled nursing care on a continuous basis, the need for a single skilled service--for example, intramuscular injections twice a week--would rarely justify a finding that the care constitutes extended care services.
- "2. The classification of a particular service as skilled is based on the technical or professional health training required to effectively perform or supervise the services. ***
- "3. The importance of a particular service to an individual patient does not necessarily make it a skilled service. ***
- "4. The possibility of adverse effects from improper performance of an otherwise unskilled service--for example, improper transfer of patients from bed to wheelchair--does not change it to a skilled service."

To participate in the Medicare program, a provider of services (a hospital or an ECF) must meet certain conditions established by law and regulations of the Secretary of HEW. Conditions of participation were included in the law to ensure that providers (1) maintained safe conditions, (2) had the facilities and organization to provide adequate and high-quality care, and (3) discouraged unnecessary utilization of their services and facilities under the Medicare program.

Under agreements with SSA, State agencies make surveys to determine whether hospitals and ECFs seeking to participate in the Medicare program meet SSA requirements. State agencies also are required to periodically make follow-up surveys to determine whether facilities continue to meet these requirements.

Fiscal intermediaries are responsible for making payments to providers for covered services furnished to Medicare beneficiaries and for serving as a channel of communication from providers to the Secretary of HEW.

CHAPTER 2

CONTROLS OVER UTILIZATION OF MEDICAL SERVICES

UNDER MEDICARE PROGRAM

The legislative history of the Medicare program shows that the Congress was concerned that the program be carried out in a manner which would provide necessary hospital care to the patients but, at the same time, that the patients would remain in hospitals only as long as necessary. To control the extent and cost of care provided to Medicare patients, the Medicare legislation provided that hospitals and ECFs institute certain procedures, to be carried out by physicians, designed to discourage unnecessary utilization of medical services and facilities.

In formulating its regulations for implementing the procedures, SSA's intention was to provide as much freedom as possible for hospitals and the medical profession to develop those procedures which were found most suitable and effective within the context of the structure, organization, and needs of individual hospitals.

The primary controls provided for in the Medicare legislation--utilization reviews and physician certification--are discussed more fully below.

UTILIZATION REVIEWS

The law provides that, to be eligible to participate in the Medicare program, hospitals and ECFs have in effect a plan for utilization review which applies to the services furnished to Medicare patients. The concept of utilization review provided for in the law is one in which physicians, working together and accountable to one another, are required to evaluate the medical necessity of medical services provided to Medicare patients in hospitals and ECFs. The recommendations of private study groups, State and national medical societies, and State agencies were considered by the Congress in developing the requirement for such reviews under the Medicare program.

To discourage unnecessary utilization of medical services, the Medicare law requires that each hospital and ECF establish a committee consisting of at least two physicians, referred to as the "utilization review committee," to review the medical necessity of admissions, duration of stays, and professional services rendered.

SSA regulations provide that the physicians serving on the committee not have a financial interest in the hospital or ECF and not be involved professionally in the cases to be reviewed, unless the Secretary of HEW determines that:

- Such financial interest is not significant and presents no conflict of interest.
- Utilization reviews could not be made otherwise because of the nonavailability of other physicians.

The Medicare law allows these utilization review committees to be staffed with physicians from the hospitals' or ECFs' medical staffs or from external groups of physicians, such as local medical societies. The law also allows providers to include on the committees other professional personnel, such as nurses, social workers, and therapists.

The committees are responsible for reviewing the necessity of continued care for all Medicare patients who have been in the institution for an extended period of time (which may differ for different classes of cases), to determine whether the patients need to receive further care in the hospital or ECF. Reports of the cognizant Senate and House legislative committees state that regulations would give the provider some leeway in determining when the review would have to be carried out and that the point at which a review would be most appropriate might vary with the diagnoses and treatments involved.

The legislative history of the Medicare program also indicated that the Congress intended that every effort would be made to move patients from hospitals to other institutions which could provide less expensive care to meet the patients' medical needs, such as skilled nursing care during the period of recovery. In view of the difference in cost of care provided in hospitals and ECFs, the Congress intended

that the possibility of providing needed medical care at less expensive facilities would be a prime concern of the utilization review committee.

SSA estimated the average cost of hospital care during fiscal year 1970 to be about \$62 a day, compared with about \$24 a day for care in an ECF.

The law authorizes the Secretary of HEW to specify the number of days of continuous care that should be considered as an extended period for purposes of utilization review. The Secretary, however, elected to allow each participating institution to specify in its utilization review plan the number of continuous days of hospital or ECF care which would be considered as an extended-duration period.

The law and SSA regulations require that the committees review cases as promptly as possible after the extended-duration period and no later than 1 week following such period. For example, if the extended-duration period established by a provider is 30 days, a case must be reviewed after the 30th day, and no later than the 37th day, from the date that the patient was admitted.

The Medicare law further provides that utilization review committees review Medicare cases, other than those which have received care for extended periods, to evaluate the medical necessity for (1) admissions of patients to the institutions for care, (2) the services being provided to the patients, and (3) lengths of patients' stays in the institutions.

As stated in the Medicare law, the objective of this review of cases, on a sample or other basis, is to promote the efficient use of services and facilities. Statistical and other data obtained from the cases selected for this review, referred to by SSA and elsewhere in this report as a "sample review," are to serve as a basis for formulating appropriate criteria for use in evaluating the medical necessity of services provided by the institution.

Medicare regulations indicate that sample reviews are expected to give particular attention to the identification and analysis of patterns of care which may indicate the possibility of inappropriate utilization of medical services.

Medicare regulations provide that, if the utilization review committee determines--after an opportunity for consultation is given to the patient's attending physician--that further stay in the institution is not medically necessary or that the needed care can be provided in other facilities at less cost, it must provide prompt written notification to the institution, the patient, and his attending physician. Prompt notification is defined as being within 48 hours of the committee's determination.

Payment under Medicare may not be made for more than 3 days of hospital or ECF care provided after the date that the notice is received by the institution. In billing the fiscal intermediary for patient care, the hospital or ECF is required to show, where applicable, the date that it received notification from the utilization review committee that further inpatient stay was no longer medically necessary.

An important benefit of effective utilization review would be to help limit Medicare coverage during the patient's stay in the hospital or ECF to the care authorized under the program and thus to minimize retroactive denials of payments to these institutions, which occur when it is subsequently discovered by fiscal intermediaries that unnecessary care or an inappropriate level of care has been provided. Retroactive denials can work hardships on hospitals and ECFs in cases in which they cannot collect from the patients and on the patients if they have to pay substantial amounts for care that they believed was covered under the Medicare program.

Various organizations participating in the administration of the Medicare program have a role in implementing the concept of utilization review. State agencies have the basic responsibilities for (1) determining whether providers have developed an acceptable plan for utilization review and (2) verifying, through on-site visits, that the utilization review committees are operating in accordance with the plan.

The fiscal intermediaries are responsible for determining whether services provided to patients are covered under the Medicare program and for making payments to providers for such services. The intermediaries are responsible also

for assisting hospitals and ECFs in the identification and evaluation of factors which impair effective utilization review. SSA instructions point out the necessity for fiscal intermediaries, in carrying out their responsibilities, to work closely with an institution's medical staff and administrative personnel and with State agencies.

PHYSICIANS' CERTIFICATIONS OF NEED FOR SERVICES

The Medicare law provides that, for a patient's stay in a hospital or an ECF to be covered under Medicare, his attending physician must certify that the stay is medically necessary.

Prior to January 1, 1970, SSA regulations required a physician's statement regarding the necessity of inpatient hospital care on or before the 14th and 21st days after admission and at least every 30 days thereafter. (Effective January 1, 1970, SSA regulations changed the requirements for the first two certifications to the 12th and 18th days.)

For a patient's stay in an ECF to be covered under Medicare, the law provides that the attending physician certify on, or soon after, admission that skilled nursing care on a continuous basis is necessary for a condition related to a previous hospital stay.

Medicare regulations require physicians to recertify the necessity of the patient's remaining in the ECF by the 14th day and at least every 30 days thereafter. At the time of each certification, the physician is required to document (1) the reasons why the patient must continue to stay in the ECF, (2) the estimated period of time that the patient will need to remain in the ECF, and (3) any plans, where appropriate, for medical care after discharge from the ECF. Claims submitted to intermediaries are required to disclose whether the physicians' certification and recertification statements are on file at the hospital or ECF for verification by the fiscal intermediary.

Although the hospital or ECF is required to obtain timely physician certifications and recertifications, SSA regulations provide that delayed statements may be honored in certain instances, if the delays are justified in writing.

CHAPTER 3

NEED TO IMPROVE CONTROLS OVER EXTENT OF CARE

PROVIDED BY HOSPITALS AND ECFs TO MEDICARE PATIENTS

The purpose of our review was to evaluate the effectiveness of the procedures established under the Medicare program for controlling the extent of care provided to Medicare patients by hospitals and ECFs. The potential significance of effective controls over the utilization of medical services is illustrated by a statement of a former Secretary of HEW, in which he estimated that Medicare costs could be reduced by as much as \$400 million annually if each Medicare patient's hospital stay could be reduced by a single day.

In our evaluation we were assisted by consulting physicians, some of whom were employed by SSA or intermediaries and others who represented State medical societies.

Our review at 41 hospitals and 49 ECFs in five States showed that the utilization review function served a useful purpose and helped, to some extent, to reduce unnecessary costs which otherwise would have been borne by the Medicare program. Actions taken by the utilization review committees at the hospitals and ECFs that we visited contributed to timely discharges of many patients who no longer required the care provided by those institutions.

We found, however, that significant problems existed in the manner in which providers implemented the requirements for utilization reviews and physicians' certifications and in the controls being exercised over these functions by SSA, intermediaries, and State agencies. Specifically we found that:

- Efforts of SSA and the intermediaries had not resulted in a full understanding, on the part of the committees, of the limitations on the type of care which properly could be covered by the Medicare program and of the importance of the committees' reviews in the intermediaries' determinations of

whether the cost of care provided should be paid for by the Medicare program.

- In many instances the committees did not act timely in consulting with the patients' attending physicians and in preparing written notices to parties affected by the committees' decisions.
- In some cases where written notices were given to the affected parties that the care provided was unnecessary, the providers' administrative staffs either did not report the information on the billings to the intermediary, contrary to SSA regulations, or reported it incorrectly.
- The criteria established by the hospitals and ECFs governing the time when individual cases were to be reviewed by committees varied widely and seemed to bear little relationship to the diagnosis or conditions for which the patients were receiving hospital or extended-care services.
- The reviews often were not made at the times specified in the providers' utilization review plans and within the time limitations established by the Medicare law.
- The committees did not review many of the extended-duration cases which, according to the providers' utilization review plans and the Medicare law, should have been reviewed.
- Several providers were not making sample reviews as required by law and SSA regulations.
- In several instances payments were made for care provided, although physicians' certifications and recertifications of the need for care in hospitals and ECFs were not on file or properly completed, contrary to law and SSA regulations.

We believe that there is a need for SSA to prepare more definite guidelines (1) concerning what utilization review committees are expected to do and the nature of

determinations needed from the committees to allow fiscal intermediaries to determine whether the services are covered under Medicare and (2) to more clearly explain to State agencies and intermediaries their intended roles in monitoring the activities of the committees.

HEW agreed that there was a need for SSA, State agencies, and intermediaries to take additional practical measures to foster the role of utilization review committees set out in the law, and HEW outlined several actions which it had taken or proposed to take to improve the utilization review function. (See app. I.) HEW officials estimated that, as a result of such actions, Medicare costs in fiscal year 1972 would be reduced by about \$60 million.

BENEFITS DERIVED FROM UTILIZATION REVIEW

At 31 of the hospitals and at the 49 ECFs included in our review, we obtained statistics that showed the results of actions taken by the utilization review committees during fiscal year 1969. The committees at these 31 hospitals examined about 14,200 cases and raised questions concerning the need for the continuation of hospital care in about 550 cases. The actions of these committees contributed to the prompt discharge of about 250 patients from the hospitals. Utilization review committees at the 49 ECFs examined about 6,000 cases and questioned the need for continued care in about 500 of the cases, which contributed to about 400 patients being discharged promptly.

We also noted that one intermediary which serviced ECFs throughout the nation had compiled statistics showing that, for about 1,000 ECFs which it served, the number of stays terminated as a result of utilization review committee decisions increased from 6.3 percent in 1968 to 8.2 percent in 1969, while the average length of stay in these ECFs declined from about 50 days to about 43 days during the same period.

In our opinion, by helping to eliminate unnecessary care provided by hospitals and ECFs, committees have contributed to reductions in costs which otherwise would have been borne by the Medicare program and by the patients.

PROBLEM AREAS AFFECTING UTILIZATION REVIEW FUNCTION

To assist us in evaluating the effectiveness of the utilization reviews, our consulting physicians reviewed the medical records for 1,735 extended-duration Medicare cases which we selected at random and gave us their professional opinions as to whether the care provided was medically necessary. The 1,735 cases included 1,003 ECF patients and 732 hospital patients at 49 ECFs and 41 hospitals in five States. From their reviews of the same medical records which had been available for examination by the providers' utilization review committees, our consulting physicians questioned in 465 cases whether the care provided should have been paid for under the Medicare program. Of the 465 cases, 351 had

also been reviewed, but not questioned, by the providers' utilization review committees.

The questions raised by our consulting physicians, which were referred to the intermediaries for their consideration and disposition as they determined appropriate, generally centered around the following issues:

- Whether a hospital patient's condition required hospital care or skilled nursing care in an ECF.
- Whether an ECF patient's condition required continuous skilled nursing care or merely custodial care.
- Whether the care needed by a patient in an ECF or a hospital could be provided on an outpatient basis.

We recognize that these issues are ones on which professional judgments may differ. Therefore we are not in a position to say how many patients should or should not have received certain levels of care. We believe, however, that these differences in professional judgment point up a number of significant problem areas which require the further attention of SSA in its efforts to achieve an effective utilization review function as part of the controls exercised over the Medicare program. These and other problem areas are discussed in the following subsections of this chapter.

Determination that patient needs
continuous skilled nursing care

One of the most difficult problems of the fiscal intermediary, in administering the Medicare program, has been to determine whether the care provided to a patient in an ECF is the type of care covered by Medicare.

The Medicare law provides that post-hospital, extended-care services be covered by the Medicare program when the individual needs or needed "skilled nursing care on a continuing basis" for treatment of a condition or conditions (1) for which the beneficiary was receiving inpatient services prior to transfer to the facility or (2) which arose while receiving extended care for treatment of a condition or conditions for which he was receiving inpatient hospital services.

The Congress intended that the program would cover high-quality convalescent and rehabilitative care in an ECF, where medically appropriate, as an alternative to inpatient hospital care. Custodial care of the type traditionally provided in nursing homes, however, is excluded specifically by law from Medicare coverage.

In their review of the medical records of 1,003 ECF patients, our consulting physicians were of the opinion that, in 354 cases, the patients did not require continuous skilled nursing care during a part of the patients' stays (or for their entire stays) in the ECFs. The consulting physicians questioned whether about 26,000 days of care provided to these 354 patients should have been paid for under the Medicare program.

In determining whether care provided in an ECF should be paid for under the Medicare program, the fiscal intermediary has to determine whether the care provided was continuous skilled nursing care, rather than a lower level of care--such as custodial care. The findings of a utilization review committee that the patient does not require continuous skilled nursing care is useful to the intermediary in determining whether the program should pay for the care provided.

Intermediary officials advised us that committees often did not understand that their role included making determinations which would serve as a basis for the intermediary in deciding whether the care provided was covered by the program and that the committees often did not understand that certain levels of care--although medically necessary--were not covered under the program. SSA regional officials and intermediary officials stated that committee members often did not have a clear understanding of the definition of continuous skilled nursing care.

Use of hospitals v. ECFs

Another problem confronting the intermediaries and the providers in their participation in the program is the consideration of whether the patient's condition requires continued inpatient hospital care or whether the needed care could be provided in ECFs at a lower cost.

The legislative history of the Medicare program shows that, although the Congress was concerned that necessary hospital care should be provided to patients, the Congress also intended that every effort would be made, at the appropriate time, to move patients from hospitals to other institutions which could provide less expensive care to meet the patients' medical needs, such as skilled nursing care during the period of recovery.

In their review of the medical records for 732 hospital patients, our consulting physicians were of the opinion that in 98 cases the condition of the patients did not require acute care during a portion of the patients' stays (or for their entire stays) in the hospital and that the needed care could have been provided in ECFs at less cost. In those 98 cases the consulting physicians questioned whether the Medicare program should have paid for 3,000 days of hospital care provided to those patients.

When a patient's medical needs can be adequately met in an ECF, rather than in a hospital, the use of an ECF generally offers significant cost advantages to the Medicare program.

Inpatient v. outpatient care

On the basis of their review of the medical records for our entire sample of 1,735 hospital and ECF cases, our consulting physicians were of the opinion that in 13 cases the condition of the patients did not require inpatient care in either an ECF or a hospital. These patients received about 1,000 days of inpatient care which our physicians questioned. With respect to these cases, the physicians were of the opinion that the needed care could have been provided on an outpatient basis.

The committees' surveillance over the determination that inpatient care is necessary has significant implications from a program cost viewpoint and is also relevant to the problem of shortage of hospital beds, which is being encountered in many areas of the country.

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HEW advised us that the decisions of utilization review committees were essentially medical determinations made by staff accountable to the providers for the purpose of ensuring proper utilization of their respective inpatient facilities and that the decisions having Medicare implications were essentially the by-product of the medical determination.

In our opinion, an understanding by the committees of the levels of care which can be covered by Medicare is important so that the committees' consideration of cases can be of maximum use to the intermediaries in their determinations of whether the cost of the care should be paid for under the Medicare program.

NEED FOR TIMELY FOLLOW-THROUGH ON QUESTIONS
RAISED BY UTILIZATION REVIEW COMMITTEES

We found that, in many cases, neither utilization review committees nor the administrative staff at hospitals and ECFs had taken timely action to follow through on cases questioned during utilization review committee meetings. The questions raised by the committees involved (1) the medical necessity of continued stays in the facility, (2) the possibility of providing needed care at other facilities at less cost, or (3) the further need for continuous skilled-nursing services.

At the 49 ECFs included in our review, utilization review committees examined more than 6,000 Medicare cases during fiscal year 1969 and raised questions on the necessity for continued care for about 500 of them, which contributed to about 400 of these patients being discharged on a timely basis. The utilization review committees at 31 of the 41 hospitals included in our review examined medical records of more than 14,000 Medicare patients during fiscal year 1969 and raised questions on the necessity for continued hospitalization for about 550 of them, of which about 250 were discharged on a timely basis.

We found, however, that about 220 of these 400 hospital and ECF patients who remained in the institution under Medicare coverage did so for periods ranging from 6 to 81 days after the committees had questioned the medical necessity for the care being provided or the appropriateness of the level of care provided. Medicare costs for this continued care totaled about \$35,000.

Our review showed that the patients remained in the institutions under Medicare coverage after committees had questioned the medical necessity of the care provided because:

- The utilization review committees did not always consult promptly with the attending physicians after they questioned the need for the patients to stay in the institution. The time elapsed before consultation, in the cases we sampled, ranged from a few hours to about 2 weeks.

- When committees had reached a decision, they seldom issued written notices to the affected parties of their determination, contrary to SSA regulations. The regulations define prompt notification as written notices to the provider, patient, and attending physician within 48 hours of the utilization review committee's determination that further inpatient stay is no longer medically necessary.

- Even when written notices were prepared, the hospitals and ECFs often did not record the information on the billing form to the intermediary, contrary to SSA regulations, or often recorded it erroneously. As a result, the intermediary often did not have timely information about the committees' determinations that would enable it to limit payments.

Intermediary, State, and SSA regional officials advised us that the SSA guidelines pertaining to written notifications by utilization review committees did not specify the period of time allowed for consultation with the attending physician before preparing a written 48-hour notification. We noted instances in which about 2 weeks elapsed between the time that a committee questioned a case and the time that it prepared a written notification of its finding.

We found that, in their survey of providers' compliance with conditions of participation, State agencies had not put much emphasis on utilization review requirements. The absence of guidance regarding the time period allowed for consultation with attending physicians and the lack of emphasis on utilization review requirements have resulted in State agencies not disclosing to SSA that hospitals and ECFs are not complying with law and regulations pertaining to timely decisions as to whether continued care is medically necessary.

We believe that SSA should consider defining more clearly the responsibilities of State agencies and intermediaries for monitoring actions taken by utilization review committees and administrative staff at hospitals and ECFs in following through on questions raised by utilization review committees. By SSA's taking these actions, intermediaries would be in a better position to identify, on a timely basis, cases where institutional care is no longer medically necessary and to terminate Medicare coverage.

DIFFERENCES IN EXTENDED-DURATION PERIODS ESTABLISHED BY PROVIDERS

We examined the utilization review plans of 682 hospitals and 1,039 ECFs serviced by the eight intermediaries included in our review. The hospitals' extended-duration periods ranged from 7 to 90 days, and those of the ECFs ranged from 6 to 100 days. The periods most frequently used were 21 days for hospitals and 30 days for ECFs. The periods used and the number of hospitals and ECFs using these periods are shown below.

<u>Extended-duration period (days)</u>	<u>Number of hospitals</u>	<u>Number of ECFs</u>
1 to 7	8	3
8 to 14	135	26
15 to 21	279	48
22 to 30	130	692
Over 30	26	211
Variable	<u>104</u>	<u>59</u>
Total	<u>682</u>	<u>1,039</u>

Officials of 35 of the 41 hospitals and of 48 of the 49 ECFs included in our review told us that their extended-duration periods had been established on one or more of the following bases: (1) arbitrarily without regard to medical factors, (2) consistent with local or prevailing institutional practices, (3) at the suggestion of State agencies or other external groups, and/or (4) for reasons unknown by present officials due to management changes.

We also were advised that four hospitals used extended-duration periods which varied depending upon the diagnoses of the patients' conditions and that two hospitals and one ECF used periods which were based on the average length of stay or on other medical factors. Officials--including physicians--of State agencies, intermediaries, and SSA regional offices advised us that extended-duration periods would be most meaningful if related to the diagnoses of the patients' conditions and the normal length of stay required to recover.

We believe that consideration should be given to establishing extended-duration periods which vary depending upon the diagnoses of the patients' illnesses and the treatments involved. We believe that this would be consistent with the law which recognizes that the extended periods can vary for different classes of cases.

Intermediary officials advised us that there was a lack of adequate and meaningful data regarding utilization of services. Although SSA instructions provided that SSA furnish the intermediaries and providers with statistical profiles on Medicare cases, such data had not been developed at the time that our fieldwork was completed. Subsequently SSA initiated a program for presenting comparative data on lengths of stays for Medicare patients discharged from short-stay hospitals and began releasing the data to the intermediaries and providers in a series of reports.

HEW advised us in February 1971 that it was hopeful that this program would accelerate progress toward the goal of developing uniform criteria for determining when a patient's case should be reviewed by a utilization review committee on the basis of the individual diagnosis and other pertinent medical factors. (See app. I.)

NONCOMPLIANCE WITH LEGISLATIVE REQUIREMENTS OF MEDICARE LAW

Our review showed a number of instances where providers were not complying with the legislative requirements regarding (1) reviews of extended-duration cases by utilization review committees, (2) sample reviews by utilization review committees, and (3) certification by physicians that care provided by hospitals and ECFs to Medicare patients was necessary.

Noncompliance with requirement concerning frequency of reviews of extended-duration cases

Medicare legislation requires that each provider have in effect a utilization review plan which provides that each extended-duration case be reviewed no later than 1 week following the last day of the extended-duration

period. SSA instructions provide that the review of each extended-duration case be made during a specific 7-day period beginning with the day that the case reaches the defined extended-duration period and ending 7 days thereafter.

To determine whether such reviews were being made as required, we selected a sample of about 1,860 hospital cases and about 1,490 ECF cases, which should have been reviewed by the committees. We found that 397 of these hospital cases and 401 of the ECF cases had not been reviewed within 1 week following the extended-duration period. In addition, 372 of the hospital cases and 284 of the ECF cases had not been reviewed at all.

ECF cases were not being reviewed within 1 week following the extended-duration period because the committees were not meeting often enough. For providers that admitted patients daily, the utilization review committee would be required to meet every 7 days to ensure timely review of all extended-duration cases. Our review showed that none of the committees at the 49 ECFs included in our review met every 7 days and that committees at only 11 ECFs met more often than once a month.

We were told by intermediary and ECF officials that the ECF committees did not meet more frequently because, in most cases, the physicians serving on the committees found it difficult to arrange their schedules for more frequent meetings.

Committees at most of the hospitals were meeting at least monthly to review cases, although they generally were not meeting frequently enough to ensure that all extended-duration cases were reviewed within the 7-day period. Consequently, in accordance with SSA instructions, most of the hospitals had established subcommittees of staff physicians to review extended-duration cases between full committee meetings. Even when providers used subcommittees, we noted instances where cases had not been reviewed on a timely basis or had not been reviewed at all because of clerical oversight.

Effective June 1970 SSA allowed an optional method of reviewing cases at hospitals having 75 beds or less, which

have extended-duration periods no longer than 21 days, and at ECFs which have extended-duration periods no longer than 30 days. Under this method committees must meet at least every 21 days at hospitals and every 30 days at ECFs and must review the cases of every Medicare patient in the facility at the time of the meeting, including those who have not yet reached the period of continuous extended duration and those who have already been reviewed at previous meetings. SSA instructions also provide that special studies should be made of the medical records of patients who have been discharged.

Under the optional method the timing of the review of current cases is dependent upon the relationship between the admission date of the patient and the date of the next committee meeting. For example, in an ECF with an extended-duration period of 30 days, the case of a patient admitted the day before the scheduled committee meeting would be reviewed after 1 day of stay, whereas the case of a patient admitted the day after the committee meeting would not be reviewed until after 29 days of stay.

SSA officials advised us that the optional method recognized the actual practice of convening committees on a monthly basis and attempted to get maximum benefit from utilization review, given the operating realities at these small institutions.

Noncompliance with requirement
for sample reviews

The Medicare law and SSA regulations require that each hospital and ECF have in effect a utilization review plan which provides for a review of cases--in addition to the review of extended-duration cases--on a sample or some other basis to evaluate the medical necessity for (1) admissions of patients to the institution for care, (2) services being provided to patients, and (3) lengths of patients' stays in the institution. As stated in the Medicare law, the objective of the sample review is to promote the efficient use of services and facilities.

SSA regulations and instructions provide that:

- Such sample reviews be specific studies, usually conducted from the medical charts of discharged patients, which give particular attention to the identification and analysis of patterns of care for groups of patients.
- At any given time some study by the utilization review committee be in process.
- The utilization review committee select a study objective that simultaneously encompasses all three areas required by law to be reviewed (admissions, lengths of stays, and services provided) or covers only one facet at a time, such as whether patients in a particular diagnostic category are discharged at appropriate time intervals.
- Once a study objective has been selected, the committee select the criteria that they believe represents optimum care, analyze the data, and report to the institution's entire medical staff their conclusions and recommendations for changes in the patterns of care, where indicated.

We found that sample reviews were not being made at four of 41 hospitals and at 13 of 49 ECFs included in our review. Sample reviews at the remaining hospitals and ECFs generally were limited to evaluations of care provided to

individual patients but were not directed to the analysis of trends and patterns affecting the overall quality of patient care in the institution.

Officials of SSA regional offices, intermediaries, and some hospitals and ECFs stated that they did not believe that the SSA requirements for sample review were clear or that the value of such reviews had been demonstrated, particularly for small ECFs where the cases of all the patients were reviewed.

For example, a physician member of a county medical society performing utilization review for about 40 ECFs, including one of the 13 included in our review that was not performing sample reviews, told us that he believed that there was no value in making sample reviews and developing statistics for each ECF, because most facilities had very few Medicare patients, the medical conditions of most ECF patients were similar, and the clerical expense of developing statistical reports would not be justified by any appreciable benefit to the patients or the facilities.

Hospital officials and utilization review committee personnel at eight hospitals in one State advised us that they were not studying patterns of patient care for one or more of the following reasons.

- Medicare patient loads were not high enough to warrant sample studies.
- The committees did not have adequate time to make studies.
- Other hospital committees had made similar studies.
- Utilization review committees were unclear on how sample review regulations were to be interpreted or how patterns of care were to be defined.

State agency officials told us that they were unable to evaluate providers' compliance with sample-review requirements because SSA had not provided specific requirements or criteria concerning matters, such as sample sizes, sample objectives, or documentation. Consequently the

State agencies reported to SSA that these institutions were complying with sample-review requirements if a hospital or ECF merely had a written plan for conducting sample reviews or was reviewing any cases other than extended-duration cases.

An SSA regional official informed us that the definition of an acceptable sample review had not been entirely resolved and that he believed that professional scrutiny of individual cases, which did not also use the cases as a basis for developing criteria for use in evaluating the medical necessity of services provided by the institution, would be inadequate.

Noncompliance with legislative
requirement for physicians' certifications

The Medicare legislation provides that payment for services furnished to beneficiaries be made only if the patients' attending physicians certify (and recertify, in accordance with regulations, where services are provided over a period of time) that the stays in hospitals or ECFs are medically necessary.

The regulations stipulate that the provider of services (a hospital or an ECF) is responsible for obtaining the required physicians' certification and recertification statements and is to certify on the billing form submitted to the intermediary that the required certification and recertification statements have been obtained and are on file for verification by the intermediary. This certification by the provider and other information on the billing, such as the diagnosis of the patients condition, period of stay, and types of treatments provided, are used by the intermediary to determine whether the care is covered by Medicare.

The regulations provide that each certification and recertification statement be signed by the physician responsible for the case or by another physician having knowledge of the case. These statements may be entered on, or included in, forms, notes, or other records used by physicians or on separate forms.

Physicians' certifications that care provided to Medicare patients is necessary are an important element in the intermediaries' determination that the medical care is necessary and can be paid for by Medicare. An SSA study completed in January 1969 showed that hospital discharges were significantly greater on the days that certifications and recertifications were required than on other days.

We found a number of cases in which payments had been made to providers for medical care for which the required physicians' certification and recertification statements were not on file or were not signed by the attending physicians.

Our review of the providers' records for 1,612 ECF patients and 2,006 hospital patients showed that:

--Of 5,579 certification and recertification statements which were required by the regulations for the ECF patients, 728 statements were not on file. An additional 12 statements were on file but had not been signed by the attending physicians.

--Of 4,574 certification and recertification statements which were required by regulations for the hospital patients, 273 were not on file. An additional 52 statements were not signed by attending physicians.

It should be noted that, under the requirements for periodic recertifications, several certifications may be required for a given patient. For the 1,612 ECF patients and 2,006 hospital patients, certification and/or recertification statements were on file for 94 percent and 96 percent, respectively, for at least some part of the patients' stays in the institutions.

Although the hospital or ECF is expected to obtain timely physician certifications or recertifications, the law and regulations provide that intermediaries may accept delayed statements, in certain instances, if the hospital or ECF justifies the delay in writing.

Our reviews of the providers' records were made from 6 to 18 months after the care had been provided to the patients at these hospitals and ECFs. We do not know the extent to which certification and recertification statements were obtained subsequent to our review.

Our review of the certification and recertification statements on file showed that 642 of the statements at ECFs had not been completed within the time required by the regulations and SSA guidelines; at the selected hospitals 341 of the statements had not been completed on a timely basis. The statements which had been prepared late generally included no explanation for the lateness.

The regulations require that the physicians' certification and recertification statements must evidence in writing

(1) the reasons for continued hospital or ECF care, (2) the estimated period of time the patient will need to remain in the facility, and (3) any plans, where appropriate, for care after discharge from the hospital or ECF.

At 31 of the 41 hospitals and at the 49 ECFs included in our review, the reasons for continued stay were not disclosed on certifications or recertifications or otherwise referenced to information in other records in 190 of 3,113 hospital statements and in 503 of 4,851 ECF statements that were on file.

Sometimes the certification and recertification statements also did not give estimates of additional care or did not indicate whether post-hospital or ECF care had been considered. For example, our review of 633 recertifications required for selected cases at 16 ECFs in one state showed that 136 recertifications did not include estimates of the additional time the patient would need to remain in the facility and that 385 did not disclose plans for further care following the ECF stay.

Some intermediary officials told us that they did not strictly enforce the requirements for estimated additional stay and plans for home care, because (1) a physician's reasons for continued care would seem to indicate that he had given consideration to the additional stay needed by the patient and (2) plans for home care was an optional requirement, as evidenced by the statement in SSA regulations that they should be included where appropriate.

Although the law provides that payments be made to hospitals and ECFs only if the required certifications and recertifications are prepared, intermediary officials advised us that they had not withheld payments for one or more of the following reasons.

- Withholding payments would penalize the hospital or ECF for noncompliance on the part of the attending physicians.
- The regulations did not provide clear criteria to determine when payments should be withheld, because certifications or recertifications may be obtained on

a delayed basis, as well as on or before specified intervals. At one intermediary, we were told that attending physicians generally filed delayed certifications and recertifications when they were not prepared on time.

--Lack of compliance was not considered sufficiently important to warrant measures as drastic as withholding payments. (One intermediary stated, however, that it planned to take such action in the future. Withholding payments would be considered only if the hospital or ECF was uncooperative in attempting to improve compliance. The intermediary believed that compliance could be effected by notification to the hospital or ECF of the problem).

Officials of one intermediary advised us that, if they found during a visit to a hospital that physician certifications and recertifications were not being properly obtained, follow-up visits were made within 3 months to determine whether improvements had been achieved. If the follow-up visits disclosed little improvement, the hospital would be required to furnish all certifications and recertifications with each claim for payment.

Intermediary officials believed that more effort was needed to make attending physicians aware of the requirements and to gain their cooperation. Regional SSA officials generally agreed that such a need existed, but they felt that firm action by intermediaries in withholding payment was also necessary. One regional SSA official stated that, after one intermediary (not included in our review) began withholding payments because certifications and recertifications had not been properly obtained, immediate and significant improvements were made by the providers in complying with these requirements. Another SSA regional official stated that delayed recertifications have been used too frequently and that more definite limitations should be imposed on the acceptance of delayed certifications and recertifications.

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We believe that a need exists for SSA to develop clearer and more definite guidelines pertaining to the responsibilities of State agencies and intermediaries, to ensure compliance with the legislative requirements for utilization reviews and physicians' certifications. We believe also that SSA should expand the extent and scope of its reviews of State agency activities, to obtain greater assurance that these agencies are enforcing compliance by hospitals and ECFs with their approved utilization review plans.

CHAPTER 4

CONCLUSIONS AND RECOMMENDATIONS

CONCLUSIONS

By SSA's taking actions to improve the carrying out of the utilization review function and to enforce more effectively the legislative requirements of the Medicare program, fiscal intermediaries would be in a better position to identify, on a more timely basis, cases involving non-covered care to patients under the Medicare program.

The timely identification of such cases, coupled with the timely termination of Medicare coverage, may result in significant reductions in the costs of noncovered care presently being charged to the Medicare program.

Furthermore such actions will also reduce the incidence of retroactive denials of benefits which occur when intermediaries discover that noncovered care has been provided. Such retroactive denials of benefits can work hardships on hospitals and ECFs in cases where they cannot collect from the patients and on the patients who may have to pay substantial amounts for care that they believe was covered under the Medicare program.

We believe that there is a need for SSA to develop more definite guidelines as to what utilization review committees are to do and the nature of determinations and documentation needed from the committees to allow fiscal intermediaries to determine whether services provided are covered under Medicare. In our opinion, an understanding by committees of the level of care which can be covered by Medicare is important so that committees' consideration of cases can be of maximum use to the intermediary in its determination of whether the care should be paid for by Medicare.

We believe that SSA should consider establishing extended-duration periods at hospitals and ECFs, which would vary depending on the diagnoses of the patients' illnesses and the treatments involved.

To improve the timeliness of terminating Medicare coverage in cases where institutional care is no longer medically necessary, we believe that SSA should consider more clearly defining the responsibilities of State agencies and intermediaries for monitoring actions taken to follow through on questions raised by utilization review committees and ensuring compliance with the legislative requirements for utilization reviews and physicians' certifications.

We believe also that SSA should expand the extent and scope of its reviews of State agency activities to obtain greater assurance that these agencies are enforcing compliance by hospitals and ECFs with their approved utilization review plans.

RECOMMENDATIONS TO THE SECRETARY
OF HEALTH, EDUCATION, AND WELFARE

We recommend that the Secretary arrange for SSA:

--To more clearly define the role of the utilization review committees in terms of the nature and objectives of the reviews that they are expected to perform, to make it clear that their decisions are essential to the intermediaries in determining whether the care provided to Medicare patients in hospitals and ECFs is covered under the Medicare program, and to more clearly define the types of care which are not covered under the program.

In commenting on this recommendation in February 1971, HEW recognized the need for improvement in the quality of the utilization review process and stated that it was in the process of taking corrective actions. HEW (1) has begun work on a teaching-training project for representatives of provider committees and officials assessing their performances and (2) is producing informational material showing useful examples of utilization review at hospitals and ECFs to supplement SSA's current instructions.

--To more clearly define the responsibilities of State agencies and intermediaries with respect to monitoring the actions taken to follow through on the

questions raised by utilization review committees and ensuring compliance with the legislative requirements regarding utilization review committees' activities and physicians' certifications and recertifications of the necessity for continued care.

HEW advised us that it would scrutinize its instructions with a view to determining whether they properly reflected SSA's intentions as to the degree of responsibilities intermediaries and State agencies were expected to assume regarding the activities of provider utilization review committees and certifications by physicians of the need for care.

--To establish more appropriate criteria for determining when cases involving stays in hospitals and ECFs should be reviewed by utilization review committees.

HEW stated that it recently had initiated a program which would enable the provider to use data regarding the normal length of hospital stay by specific diagnosis, to establish when cases should be reviewed by utilization review committees. HEW stated that it was hopeful that this and other developments would accelerate progress toward the goal of our recommendation.

--To provide for increased attention, in SSA's reviews, to whether State agencies are doing an adequate job of determining the degree of compliance by hospitals and ECFs with their approved utilization review plans.

HEW advised us that several programs had been instituted to evaluate the operational effectiveness of the State agencies and to ensure the full cooperation of participating facilities in improving their operations. HEW stated that its efforts would be reevaluated intensively in light of our findings.

CHAPTER 5

SCOPE OF REVIEW

Our examination included a review of Medicare legislation and the related regulations and was directed toward an evaluation of the effectiveness of the utilization review function at hospitals and ECFs participating in the Medicare program. The review included (1) an examination of the regulations and instructions promulgated by SSA, (2) an examination of the role of State agencies and fiscal intermediaries in controlling the utilization of medical services by Medicare patients, and (3) a test of the manner in which the legislative and administrative controls were applied at hospitals and ECFs.

Our review was made at 41 hospitals in California, Colorado, Michigan, and Ohio; at 49 ECFs in California and New York; and at five State agencies and eight intermediaries located in the aforementioned States.

During fiscal year 1969 the eight intermediaries included in our review made Medicare part A benefit payments totaling about \$1.3 billion, or approximately 27 percent of the total Medicare part A payments made during the year; the hospitals and ECFs included in our review were reimbursed for costs of \$42.4 million and \$8.4 million, respectively.

Variations in the sizes of the hospitals and ECFs included in our review are shown below.

<u>Number of beds</u>	<u>Hospitals</u>	<u>ECFs</u>
50 or less	5	8
51 to 100	9	25
101 to 200	13	12
201 to 500	12	3
501 to 1,000	1	1
Over 1,000	<u>1</u>	<u>0</u>
Total	<u>41</u>	<u>49</u>

At the hospitals and ECFs, we randomly selected a sample of cases for use in evaluating the timeliness and effectiveness of the utilization reviews. We also reviewed a sample of cases at these facilities to ascertain whether the required certifications and recertifications of the necessity for continuation of care had been made by the Medicare patients' attending physicians in the manner prescribed by SSA. At the State agencies and intermediaries, we examined the procedures and practices followed by these organizations in monitoring the activities of utilization review committees.

APPENDIXES



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

WASHINGTON, D.C. 20201

OFFICE OF THE SECRETARY

FEB 16 1971

Mr. Philip Charam
Associate Director, Civil Division
United States General Accounting Office
Washington, D. C. 20548

Dear Mr. Charam:

Enclosed is a revision of the response I submitted on December 28, 1970 to your draft audit report entitled, "Need to Strengthen Controls Over Utilization of Medical Facilities Under the Medicare Program." Our comments have been modified to reflect the changes in the revised draft of this audit report which was given to representatives of the Social Security Administration by Mr. Fred D. Layton.

Sincerely yours,


James B. Cardwell
Assistant Secretary, Comptroller

Enclosure

APPENDIX I

NEED TO STRENGTHEN CONTROLS OVER UTILIZATION OF MEDICAL FACILITIES UNDER THE MEDICARE PROGRAM (GAO Draft Report Transmitted September 23, 1970)

The audit report indicates that much remains to be done to improve the effectiveness of utilization review at hospitals and extended care facilities. We will continue to direct our attention to this objective. To put this matter in perspective, it must be recalled that, when Medicare began operations, utilization review was virtually unknown in many areas and, where it did exist, it frequently did not encompass all of the activities envisioned by the Medicare legislation. In this context, the accomplishments of utilization reviews, such as those set out in the section of Chapter 3 captioned "Benefits Derived From Utilization Review", are a tangible measure of the very substantial progress that has been achieved to date through the concerted efforts of the Social Security Administration, the Public Health Service, State agencies, and health insurance intermediaries. This evidence indicates the viability of provider utilization review as a mechanism to promote more effective use of limited inpatient facilities, and thus to help contain Medicare costs.

We agree that there is a need for SSA, State agencies, and health insurance intermediaries to take additional practical measures to increase the effectiveness of utilization review. These measures must be designed to foster the role of utilization review committees set out in the law. Except insofar as the result flows indirectly and by implication from their activities, it is not the function of the committees to make determinations of Medicare coverage. Utilization review was originally conceived as a function of the professional medical community to promote more effective use of medical resources. Although the decisions made by utilization review committees do have Medicare coverage implications, this is essentially the by-product of a decision clearly indicating that services are medically inappropriate or no longer necessary. A converse decision does not necessarily have to address itself to the question of Medicare coverage.

The decisions of utilization review committees are essentially medical determinations made by staff accountable to the providers for the purpose of assuring proper utilization of their respective inpatient facilities. It is true that Congress sought to give impetus to the growth of the utilization review concept and to make use of it in controlling Medicare costs by requiring providers to carry out utilization review as a condition for participation, etc. However, as correctly stated on [page 9 of this] report, the concept of utilization review provided for in the law is one in which physicians, working together and accountable to one another, are required to evaluate the medical necessity of medical services provided to patients.

This is not to imply that improvement in utilization review will have inconsequential effects on program coverage decisions.

[See GAO note]

Steps that have been taken or will be taken to deal with these problems are discussed below in relation to GAO's four specific recommendations.

1. Recommendation: That SSA more clearly define the role of the utilization review committees in terms of the nature and objectives of the reviews they are expected to perform, to make it clear that their decisions are an essential tool to the intermediary in determining whether the care provided to Medicare patients in hospitals and ECF's is covered under the Medicare program, and to more clearly define the types of care which are not covered under the program.

We have for some time recognized the need for improvement in the quality of the utilization review process and we are in the process of taking

GAO note: Deleted comments relate to matters which were presented in draft report but revised in this final report.

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corrective actions. We have already begun work on a teaching-training project, which we feel is basic to producing well-functioning utilization review. At present, there is no private institution that offers training in utilization review. However, a training institute is being developed under a Public Health Service grant contract. The first session is to be held next spring for representatives from provider committees and officials assessing their performance.

In addition, we have produced informational material on utilization review at hospitals to supplement instructions contained in SSA's State Operations Manual (HIM-7). This material, which we recently published as Appendix E to the manual, pulls together information from a wide variety of published and unpublished sources relating to the performance of reviews at hospitals. The aim is to supply useful examples and discussions of a practical nature on proven practices and procedures, and to furnish copies of utilization review forms and formats in present use. We are working on supplemental materials relating to extended care facilities but anticipate greater difficulty because of the dearth of pre-Medicare experience with any type of utilization review involving these providers and the corresponding lack of published materials.

An additional printing of Appendix E is being distributed to State surveyors to use as a teaching tool during their visits to each hospital and ECF utilization review committee and to State and local medical societies. There are also plans to release the Appendix to intermediaries.

We hope that these steps will aid in the improvement of utilization review activity in the spirit of GAO's recommendation.

The law places responsibility for making coverage determinations on the intermediary. This was further clarified in the intermediary agreements of July 1, 1970. Article II, A states that the intermediary shall, "Make determinations as to whether the services provided an individual are covered services...." The role of the utilization review committee is set forth in section 1861(k) of the Social Security Act which requires that these committees review admission and duration of stays with respect to the medical necessity of the services provided and for the purpose of promoting the most efficient use of available health facilities and services.

We think that this distinction between the intermediary and the utilization review committee role is important; it seems reasonable that a physician or a committee may make a judgment of medical necessity without regard to Medicare coverage. It is our view that the intermediary should take the physician determination (on certification or recertification) and the utilization review committee determination regarding medical necessity and translate them into a determination of coverage. As such, the utilization review committee decision is only a part of the medical evidence used by the intermediary in its determination of coverage.

2. Recommendation: That SSA more clearly define the responsibilities of State agencies and intermediaries with respect to policing the: (1) activities of utilization review committees, (2) actions taken by the facilities to follow-up on the decisions of the committees, and, (3) compliance by physicians with the requirements for certification and recertification to the necessity for continued care.

The responsibilities of State agencies and intermediaries in the areas mentioned are defined in considerable detail in the State Operations Manual and the Part A Intermediary Manual. SSA's basic policy on the respective roles of the States and intermediaries in utilization review is set out in State Agency Letter No. 73 and in Intermediary Letter No. 248, which were issued in 1967. Despite these issuances, however, there continues to be some overlap so that we are taking a close look at whether they can be clarified to eliminate overlap that may be unnecessary. At the same time, we will scrutinize our instructions with a view to whether they properly reflect SSA's intentions as to the degree of responsibility intermediaries and State agencies are expected to assume regarding the activities of provider utilization review committees and certifications by physicians of the need for care.

In any program as complex as Medicare, a degree of overlapping of responsibility inevitably results. The law gives State agencies the responsibility of determining the compliance of providers of services with the conditions for participation, one of which is utilization review. The law also charges the intermediaries with assisting the providers in the application of safeguards against unnecessary utilization of services. However, steps are being taken to identify and eliminate unnecessary duplication wherever possible.

3. Recommendation: Establish more appropriate and uniform criteria for determining when cases involving stays in hospitals and ECF's should be reviewed by utilization review committees

On page [25 of this] report, GAO concludes that "extended duration periods should be related to normal lengths of stay by specific diagnosis". Further, on page [36], it is suggested that SSA consider "the desirability of developing uniform criteria for determining when a patient's case should be reviewed by a utilization review committee on the basis of individual diagnoses and other pertinent medical factors instead of arbitrary criteria presently being used by hospitals and ECF's". It appears the audit recommendation stems from these conclusions.

We agree that more use of the type of criteria envisioned by GAO would be very desirable. We have actively encouraged this and our efforts have resulted in more hospitals adopting such criteria. Up to now, however, progress has been inhibited by the absence of reliable statistics

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and data on length of stay, etc. Recently, SSA initiated the Medical Analysis of Days of Care (MADOC) program, which is discussed under our general comments below. In addition, more data is becoming available from private sources such as the Professional Activities Study (PAS) of the Commission on Professional and Hospital Activities, Ann Arbor, Michigan. We are hopeful that these developments will accelerate progress toward the goal of this audit recommendation.

4. Recommendation: Provide for increased attention, in SSA's own reviews, to whether State agencies are doing an adequate job of determining the degree of compliance by hospitals and ECF's with their approved utilization review plans

SSA has been constantly working toward upgrading the quality of medical care and services under the Medicare program. Toward this end, several programs have been instituted to evaluate the operational effectiveness of the State agencies and to ensure the full cooperation of participating facilities in improving their operations.

In conjunction with the Public Health Service, SSA conducts program reviews of each Medicare State agency. Also, each of the Bureau of Health Insurance (BHI) regional offices conducts comprehensive reviews of State operations. These reviews include, among other quality controls, direct surveys of a sample of providers to determine the effectiveness and adherence to Federal guidelines of the State surveyors.

In addition, measures have been instituted to improve the quality of State agency professional employees. The third in a series of training programs for State agency survey personnel is being held at Tulane University and similar institutes are being started in three other universities. Approximately 300 surveyors will receive this training in 1971 and, ultimately, all surveyors will receive such training at various BHI-sponsored institutes throughout the country. We have also been working closely with State and Federal merit system officials in an effort to upgrade and augment State Medicare agency staffing.

This is all a part of our total effort to upgrade the capabilities of the State agencies. Review of utilization review has always been an important part of the State agencies' function and has been receiving our increased attention. Our efforts will be intensively reevaluated in the light of the GAO findings.

* * * * *

In addition to our comments on the recommendations, we have the following general comments:

On page [25], it is stated that some intermediary officials cited a lack of adequate and meaningful data relating to the utilization of services as one reason why utilization review committees do not make good decisions.

As part of a continuing effort to promote the most efficient use of available hospital facilities and services, SSA has developed a program for presenting comparative data on lengths of stays of Medicare patients discharged from short-stay hospitals. The data are being released in a series of reports entitled, "Medicare Analysis of Days of Care" (MADOC) which will be issued semi-annually to short-stay hospitals, their intermediaries, and State agencies.

The purpose of the MADOC reports is to provide data to help hospitals assess and improve their utilization practices. The data has been designed to identify those hospitals whose average actual length of stay differs significantly from the estimated length of stay based on the experience of all hospitals in the same area. The technique used in MADOC takes into account differences in hospital characteristics, in the medical and demographic characteristics of each hospital's patients, in the treatment given patients, and in specific geographic location.

Actual data for the last six months of 1969 was sent to providers, intermediaries, and State agencies during November 1970. Succeeding reports will include data based on discharges during successive six-month periods, i.e., January-June 1970, July-December 1970, and will be distributed semi-annually. More detailed information on MADOC may be found in State Agency Letter No. 150 or Part A Intermediary Letter No. 70-34, both of which were released in November.

MADOC was developed with the active participation of a joint intermediary-SSA work group. Work has begun to develop similar data for extended care facilities. An advisory group of both intermediary and SSA personnel has also been established to assist in this work.

On page [25] GAO is critical of the utilization review committees not meeting every seven days to review all extended duration cases coming due. From the outset we recognized that this might be a problem and suggested that this could be a subcommittee activity using physician-delegates to do the initial review and screening of cases. This method was discussed in State Agency Letter No. 125 dated November 20, 1968.

[sic]

The problem and expense of convening ^Aphysician committees on more than a monthly basis preceded Medicare. Voluntary accrediting organizations have accepted the monthly interval as satisfactory for usual committee purposes. Because of payment considerations, we try to promote more frequent meetings wherever feasible. However, our compromise, the so-called optional method for small hospitals and ECF's, recognizes the actual practice of convening committees on a monthly basis and attempts to get the maximum benefit from utilization review given the operating realities at these small institutions.

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We would like to point out that under the optional method the initial review then constitutes the miscellaneous sample for medical necessity of admission, professional services rendered, and duration of stay to date. When the physician certification was set at 14 days, it was noted there was a peaking of discharges on that date, with the result that the date for certification was revised to 12 days in an attempt to reduce the length of hospital stay further. We hope to see a similar fall out of discharges prior to the committee review date in facilities using the optional method.

PRINCIPAL OFFICIALS OF
THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
RESPONSIBLE FOR ADMINISTRATION OF ACTIVITIES
DISCUSSED IN THIS REPORT

	<u>Tenure of office</u>	
	<u>From</u>	<u>To</u>
SECRETARY OF HEALTH, EDUCATION, AND WELFARE:		
Elliot L. Richardson	June 1970	Present
Robert H. Finch	Jan. 1969	June 1970
Wilbur J. Cohen	Mar. 1968	Jan. 1969
John W. Gardner	Aug. 1965	Mar. 1968
COMMISSIONER OF SOCIAL SECURITY:		
Robert M. Ball	Apr. 1962	Present
DIRECTOR, BUREAU OF HEALTH INSUR- ANCE (note a):		
Thomas M. Tierney	Apr. 1967	Present
Arthur E. Hess	July 1965	Apr. 1967

^aThe Bureau of Health Insurance was a part of the Bureau of Disability and Health Insurance until September 1965. At that time separate bureaus were established to handle the functions of the disability program and the health insurance program.