MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
HEALTH CARE FINANCING ADMINISTRATION

TO: The Secretary
Through: US _______
ES _______

FROM: Administrator,
Health Care Financing Administration

SUBJECT: Additional Cost-Saving Initiatives — ACTION

In preparation for your budget meeting with President Carter, we have prepared a list of possible initiatives in the health area which would produce both Federal and system-wide savings in health expenditures. Most of the suggested initiatives involve major policy shifts or legislative changes which warrant considerable discussion and exploration.

Although these initiatives will undoubtedly generate controversy Among health care institutions, physicians, insurers, and consumers, many can have a substantial impact on controlling rising health care costs and the Federal health financing budget.

The savings initiatives are grouped into two categories:

1. Program management — Initiatives which would produce savings from improved administration, e.g., improved quality control in Medicaid.

2. Program policy — Initiatives which would yield savings by modifying program benefits, financing burden or the health care delivery system.

Almost all initiatives would require legislation and some would require additional resources to implement. The savings indicated for initiatives in the second grouping are guess estimates at best. Thus, we need to be very cautious in calculating hos much of a budget reduction they might yield or their political and administrative feasibility.

If you wish I will gladly go over the listed initiatives in more detail with you before your meeting with the President.

Robert A. Derzon

Attachment

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I. PROGRAM MANAGEMENT INITIATIVES

Improved Medicaid Quality Control

If the present 7 percent level of ineligibility errors continues into FY 1979, $1,600 million ($880 Federal) will be misspent on Medicaid payments for ineligible recipients. Our experience with AFDC Quality Control shows, that this error rate is reduceable if States are faced with the threat of a fiscal penalty for excessive error rates. We have in place the Medicaid Quality Control (MEQC) program and with the addition, through legislation, of a penalty provision we would be in a position to expect a reduction of Medicaid ineligibility errors and associated dollar losses. We also need an additional 125 (for the MEQC system and Technical Assistance) to support this error reduction effort.

Assuming the required legislation and resources become available in FY 1978, we can expect conservatively to reduce the error rate by 1 percent per year and produce Federal dollar savings as follows:

	FY 1979	FY 1980	FY 1981
Lower ineligibility error	$100	$130	$150 Mil.
Ineligibility penalty	140	130	110
Combined	240	260	260

The penalty figure is calculated on the basis of a 75th percentile tolerance (States with an error rate above the 75th percentile of the national error rate get penalized for the amount of Federal payments misspent above this tolerance). Lowering the tolerance would produce greater savings at a rate of an additional $200 million per 25th percentile.

Improved Third-Party Liability Recovery, Claims Processing Error Control

Presently, we estimate a loss of $600 million per year in unrecovered Third-Party Liabilities and $200 million per year in Claims Processing Errors (duplicate payments, etc.). The Medicaid Qualtiy Control System is being modified to measure the exact level of loss in these areas. A technical assistance effort backed with legislation providing for a dollar loss tolerance and a fiscal penalty for States exceeding this tolerance, can reduce this loss by 50-75 percent. Federal dollar savings would be as follows:

	FY 1979	FY 1980	FY 1981
Third-Party Liability Recoveries	$80	$80	$80 Mil.
Claims Processing Errors	80	80	80
Penalty	20	20	20
Savings Combined	180	180	180

Improved Control of Provider Fraud and Abuse

Loss from provider fraud and abuse in Medicaid is estimated at $800-$900 million per year. This level of loss can be reduced by an intensified fraud and abuse program integrity effort consisting of expanded investigations along the lines of Project 500, better use of provider profiling and follow-up techniques and introduction of a Civil Money Penalty Program. This program would empower the Secretary to levy a civil penalty of up to $1,000 against persons who make Medicaid claims to a Federal or State agency in excess of the amount lawfully owed them. The Secretary is provided with the authority to "impose" such penalties with limited jucicial review in U.S. District Court.

Based on reviews of Medicaid providers, or leads generated from referrals from other agencies or outside sources, an initial review of the provider's practice is made. Any case appropriate for potential fraud prosecution is referred to the Office of the Inspector General, while all other cases are maintained within Program Integrity. If, after further review by Program Integrity,

is determined that an overpayment was made, and, unless the provider can justify those payments or agrees to restitution (and in some cases a penalty), a judgment will be made against him. If the provider is not satisfied with the determination and that determination is confirmed, a full hearings process is available.

The costs of this effort would include an additional 60 positions ($2.5 million per year) for HCFA Regional Offices plus an additional 340 positions for investigation and case preparation. Depending upon whether these positions are filled at the State or Federal level, the Federal share of this increase in resources will range between $5 million and $10 million. The total cost of the program then will range between approximately $7.5 million and $12.5 million. The expected savings would be:

	FY 1979	FY 1980	FY 1981
Recoveries	$67	$89	$103 Mil.
Penalty Combined	150	165	180

II PROGRAM POLICY

Physician Reimbursement Reforms

Controls could be developed to contain the rate of increase in physician reimbursement. Consideration could be given to applying reimbursement controls similar to those under the Administration's proposed Hospital Cost Containment Act of 1977 to physician reimbursement. Further, incentives could be developed to assure that physician services are rendered in as efficient a manner as possible and not in excess of a level of care consistent with the patients medical care needs. In this regard, consideration could be given to an extension of the National Health Planning and Resources Development Act of 1974 to limit the availability of physician services to an amount commensurate with area needs. Fro example, in an area in which the health planning authority has determined the availability of hospital-based computed axial tomography (CAT) scanners to be adequate to meet community needs, reimbursement for such services could be denied to physicians for services performed on office-based equipment. In order to assure the effectiveness of controls in restraining the rate of increase in physician reimbursement and to avoid disruption in the availability of physician services to all segments of the population, any form of physician reimbursement control should be applied universally to all third-party payors and to direct (out-of-pocket) payments.

In the absence of direct controls on the rate of increase in physician reimbursement, it is expected that the rate of increase in physician fees in the period 1977-1980 will be aproximately 50 percent greater than the rate of increase in the Consumer Price Index (CPI). These increases in physician fees will in large part be translated into comparable increases in Federal outlays for physician reimbursement. However, any effort to exert direct controls over physician reimbursement could be expected to encounter strong opposition from physician organizations. Further, direct controls would require the development of an administrative mechanism to assure physician compliance with the requirements of the law.

If FY 1976 expenditures for physician services had been held to the increase in the CPI, for example, Federal spending would have been reduced by over $400 million and total health care expenditures by over $2 billion.

Dynamic Part B Deductible

Despite rising medical care costs and improvements in beneficiary income, the part B deductible amount has been fixed by law at $60 per calendar year since 1973. The deductible could be increased to reflect this experience, and the deductible provision of the law amended to provide for increasing the deductible amount in future years in relation to increases in social security cash benefits.

This proposal would undoubtedly be strongly resisted by senior citizens groups such as the American Association of Retired Persons and the National Council of Senior Citizens, since it would increase beneficiary out-of-pocket expense.

If the part B deductible amount were increased from $60 to $75 in calendar year 1978, Medicare outlays in FY 1979 would be reduced by about $200 million. There would be no system-wide savings, only a transfer of expenditures from the Federal budget to the private sector.

Constraining the Supply of Physicians

There is ample evidence that sheer increased availability of resources, such as surgeons or hospital beds, acts to increase utilization and thus total expenditures. Today, the U.S. is seeing an extremely rapid increase in the number of medical students and medical schools due, in large part, to support from HEW. However, this increase is counterproductive since we do not need to increase our physician supply, only to change its distribution by specialty and geographic area. A major consequence of this significant expansion in the pool of physicians will be increased medical care costs as these new physicians begin their practices. The critically important factor is the physician's apparent ability to influence the demand for his services and his ability to use this induced demand to produce the income level desired. HEW manpower policies should be changed when necessary to constrain the number of physicians produced and to redirect the supply of physicians away from specialization and into primary care.

Resistance from the medical profession to any attempts to change the distribution of physicians among specialties should be expected. However, P.L. 94-484 already requires 50 percent of all residencies to be in primary care by 1980. Thus, much of the desired realignment in specialty versus primary care practice can be accomplished by implementing and strengthening P.L. 94-484. Strong resistance to reducing the output of medical schools can be expected from prospective students and the medical schools themselves. However, the AMA has traditionally sought to limit the number of physicians and, therefore, might not resist.

Curbing the number of physicians produced and redirecting physician training to primary care will not have any immediate savings, but will result in significant savings in the future. By 1980, there will be 85,000 more physicians than there are today, generating about $5 billion in annual income and even more in hospital costs. These physicians are already in medical school, but curbing future enrollment will prevent exacerbating the problem. Shifting physicians toward primary care will also significantly reduce expenditures. Today, only one-fourth of office-based physicians are in primary care, yet it has been shown that the addition of one primary care physician to a State's physician pool would decrease hospital costs by $39,000 while adding a specialist would increase costs by $39,000.

Reduce Utilization Through Broader Application of the HMO Concept

Incentives should be provided for expanding the HMO capitation payment model to include additional group practices and other types of health care delivery settings. Solo-practice physicians could be paid on a capitation basis rather than fee-for-service basis for the preventive and routine services they provide to patients. Depending upon the amount of care for which they are at risk, physicians and providers would be encouraged by the capitation method to avoid overutilization of services. In addition, capitation payment could discourage physicians from practicing defensive medicine — such as unnecessary testing and questionable procedures.

It is likely that there would be some resistance to capitation on the part of fee-for-service physicians who now gain financially from providing excess services, performing operations, and placing people in hospitals.

Assuming that expenditures for physician services could be reduced by only 10 percent in calendar year 1978, for example, Federal spending would be reduced by almost $690 million and total health care expenditures would be reduced by over $3 billion. Additional savings would accrue from a reduction in hosptial use as well.

Change Federal Medicaid Matching Formula

This cost-saving plan reduces Federal Medicaid spending in the richest States (in terms of per capita income) by either lowering the 50 percent Federal matching rate or imposing a ceiling on Federal funds. The ceiling could be on a per-recipeint basis or on aggregate levels. Although the federal matching share for Medicaid is lowest in the richest States (50 percent vs. up to 78.28 percent), overall these rich States still receive the most Federal dollars. These States tend to choose and can better afford the most comprehensive benefit packages, the most liberal eligibility requirements, etc. As a result, the poor States are, in essence, subsidizing the rich ones through their contributions to Federal taxes, and the rich States often have spending levels far exceeding Federal expectations.

Reduction of the Federal Medicaid share is contrary to the current thinking toward increased or total Federal involvement. The National Association of State Governments is currently requesting relief of some of their Medicaid burden. The States would be extremely resistant to any attempt to shift more of the burden on them. It could result in the elimination of some benefits which would cause strong resistance from the recipients and their advocates. Choosing to lower the 50 percent matching rate would affect just New York, Callifornia, and maybe Illinois, but the effect on them would obviously be much greater.

Since Federal expenditures to the 50-percent-States represent about 55 percent of Federal Medicaid outlays, a relatively small reduction in the matching rate could have relatively large savings. Reducing the rate to 45 percent, for example, would reduce projected Federal Medicaid outlays of $12 billion in FY 1978 by over $300 million. To save $300 million in 2 or 3 States would require drastic cuts in spending levels.

Modify State Reimbursement of ICF's and SNF's

Prior to the enactment of section 249 of P.L. 92-603, States were free to develop their own bases for reimbursement of skilled nursing facilities (SNF's) and intermediate care facilities (ICF's) under Medicaid. Section 249 required the States to reimburse skilled nursing and intermediate care facilities on a reasonable cost-related basis using methods approved by the Secretary. This section was included in the law partly because of concern that some States were paying SNF's and ICF's too little. Repeal of this section would reduce State reimbursement to SNF's and ICF's, which in turn would lower the amount of Federal matching.

There would probably be considerable opposition to the proposal. The American Health Care Association has filed suit in protest of the Department's decision to delay the implementation of the section 249 regulations until January 1, 1978; it almost surely would fight repeal of this section. Furthermore, some consumer groups would oppose it on the grounds that State rates would be too low to provide the quality of care that Medicaid patients will need.

If section 249 were not implemented in calendar year 1978, the Federal saving would be close to $30 million in that year, and total savings would be over $50 million.

Strengthening Planning Controls to Reduce Capital Expenditures

One of the major contributors to the rise in health care costs is excess hospital capacity. Title II of H.R. 6575 begins to address this problem by placing a moratorium on new bed construction and a national limit of $2.5 billion for new major capital expenditures. However, H.R. 6575 relies on attrition to reduce existing excess capacity over time and grandfathers in between $3 and $6 billion of approved, but not yet begun, construction. Immediate action to restrict the flow of capital through depreciation, to reduce the level of grandfathered capital under H.R. 6575, to eliminate excess existing capacity and to restrict Federal financing of hospital capital investment will produce substantial savings in both the health care sector and the Federal health budget.

A significant amount of Federal health expenditures goes to hospitals to cover depreciation and interest costs. Medicare, for example, will pay about $1 billion in 1977 for depreciation and interest. Existing depreciation reimbursement policy is essentially based on a hospital's existing

assets rather than its community's need. Pooled depreciation would promote rational resource allocation and strengthen planning controls by allowing States or regional planning agencies to allocate capital dollars and control the availability of health services in their area. Second, excess capacity could be eliminated by closing down unneeded beds or facilities or consolidating facilities and services. The former could be accomplished by down-licensing on the basis of prior occupancy or by buying out unneeded capacity. The latter could be accomplished by placing a moratorium on capital flow to facilities with excess capacity. Third, the grandfather problem could be alleviated by requiring recertification of all approved capital projects not yet under construction. Fourth, we could reduce the Federal financing of construction. The Hill-Burton program, HUD, and other Federal grants account for one-fourth ($1.3 billion in 1978) of all hospital construction funds.

Pooled depreciation will meet significant resistance from the hospital industry which will assert that depreciation payments are for replacement of existing capital and that hospitals should not be penalized for past purchases. However, hospitals have been using depreciation funds for operating costs and new non-replacement capital. Reduction of excess capacity as an overall policy would be well-received, but resistance to local application of the policy should be anticipated.

The major cost-savings would be in reducing excess capacity which will significantly reduce operating costs. Elimination of the 100,000 excess beds in the U.S. would result in Federal savings of about $500 million and system-wide savings of up to $2 billion in annual operating costs. Moreover, for every $1 of capital expenditure prevented through recertification, Federal financing, or depreciation pooling, 50t in the next year's operating costs would be saved overall and 20t federally. If $2 billion of capital expenditures are prevented, $1 billion in overall operating costs will be saved.

Change Social Values Regarding Cost-Inducing Activities

A. Encourage Adoption of "Living Wills"

The "Living Will" concept allows patients to legally require the cessation of the employment of extraoridnary means to prolong life when there is irrefutable evidence that biological death is imminent. The first such law was enacted in California in September 1966, and legislators in 16 other States sought to delineate rights for the terminally ill during that year. The statutes make provision for a person to declare in advance what he would wish done if he should reach a moribund condition and be incapable of expressing his wishes. It relieves the physician and/or health facility of any liability. Prior to passage in California, 87 percent of persons polled there thought that an incurably ill patient should ha the right to refuse life-prolonging medication. Encouraging States to pass such a law or, more strongly, withholding Federal funds without passage would serve to heighten public awareness of the use of such resources and would also lower health spending when such wills are executed.

The strong response to the Karen Ann Quinlan case demonstrates that such encouragement would result in some negative public reaction. Although the Catholic Church ruled that extraordinary measures need not be employed, there is still religious resistance to this concept.

The cost-savings from a nationwide push toward "Living Wills" is likely to be enormous. Over one-fifth of Medicare expenditures are for persons in their last year of life. Thus, in FY 1978, $4.9 billion will be spent for such persons and if just one-quarter of these expenditures were avoided through adoption of "Living Wills," the savings under Medicare alone would amount to $1.2 billion. Additional Federal savings would accrue to Medicaid and the VA and Defense Department health programs.

B. Reduce Unwanted Births

In 1973, about 36 percent of all women aged 15-44 eligible for Medicaid received abortions in States covering abortions. Add to this the proportion of unwanted pregnancies where abortion was rejected, and it is possible that close to half the welfare recipients of child-bearing age have

unwanted pregnancies in a single year. In 1976, there were 3.5 million AFDC families, nearly all of whom have women of child-bearing age. The costs of caring for these potentially unwanted births, under both Medicaid and welfare, is staggering. To reduce unwanted births, the Administration can reverse its decision not to cover abortions under Medicaid and/or intensively counsel and provide birth control assistance.

The second alternative, intensifying Federal birth control efforts, is consistent with President Carter's preferences. I would require additional funds to implement an effective program, reaching teenagers as well as adults. Nevertheless, the resulting savings would far outweigh the costs and the political ramifications would not be substantial. Covering abortions under Medicaid would be more effective in preventing unwanted births and would have far greater savings, but also far greater ramifications. In addition to being contrary to the President's current stand, it would incur the anger of the Catholic Church, the "Right to Life Groups," etc.

The cost-savings under either alternative are difficult to estimate, but every unwanted birth prevented saves about $1,000 annually in welfare payments and another $100 in Medicaid funds.

C. Increase Efforts to Educate Public on the Benefits of Changing Their Lifestyle

An ever-increasing body of evidence demonstrates that one's lifestyle has a far greater influence on one's health status than medical care. Smoking, excess drinking, lack of exercise, obesity, and drugs contribute significantly toward death and disability. Educating the public to the benefits of positive health would have little negative political reaction. Imposing sanctions, such as differential insurance or tax rates, would probably be more effective, but would meet tremendous opposition.

A national health education and behavior modification program would reduce health care costs enormously, but its effects would not be felt in the near future. Nevertheless, a successful program to alter lifestyles would have such a significant impact on costs and lives that it should not be rejected because it lacks immediate payoffs.