
Department of Health and Human Services

Office of Inspector General

Cost-Saver Handbook



2004
RED BOOK

Office of Inspector General

Under the authority of the Inspector General Act of 1978, as amended, we improve Department of Health and Human Services (HHS) programs and operations and protect them against fraud, waste, and abuse. By conducting independent and objective audits, evaluations, and investigations, we provide timely, useful, and reliable information and advice to Department officials, the administration, the Congress, and the public. Our statutory mission is carried out by the following operating components.

Office of Audit Services

OIG's Office of Audit Services (OAS) provides auditing services for the Department, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations in order to reduce waste, abuse, and mismanagement and to promote economy and efficiency throughout the Department.

Office of Evaluation and Inspections

OIG's Office of Evaluation and Inspections (OEI) conducts short-term management and program evaluations (called inspections) that focus on issues of concern to the Department, the Congress, and the public. The findings and recommendations contained in the inspections reports generate rapid, accurate, and up-to-date information on the efficiency, vulnerability, and effectiveness of departmental programs. OEI also oversees State Medicaid fraud control units, which investigate and prosecute fraud and patient abuse in the Medicaid program.

Office of Investigations

OIG's Office of Investigations (OI) conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. These investigative efforts lead to criminal convictions, administrative sanctions, or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support in OIG's internal operations. OCIG imposes program exclusions and civil monetary penalties on health care providers and litigates those actions within the Department. OCIG also represents OIG in the global settlement of cases arising under the Civil False Claims Act, develops and monitors corporate integrity agreements, develops model compliance plans, renders advisory opinions on OIG sanctions to the health care community, and issues fraud alerts and other industry guidance.

Introduction

Purpose of the Red Book

The *Red Book* is a compendium of significant Office of Inspector General (OIG) cost-saving recommendations that have not been fully implemented. These recommendations may require one of three types of actions: legislative, regulatory, or procedural (such as manual revisions). Some complex issues involve two or all three types of actions.

The Inspector General Act requires that the OIG's semiannual reports to the Congress include "an identification of each significant recommendation described in previous semiannual reports on which corrective action has not been completed." Thus, appendices to each semiannual report list significant unimplemented recommendations. Because of the abbreviated nature of that list, however, we prepare the *Red Book* to further highlight the potentially significant impact of cost-saving recommendations.

The savings estimates indicated for these unimplemented recommendations are updated from time to time to reflect more current information as it becomes available. The estimates have varying levels of precision. Full implementation of the recommendations in the 2004 edition of the *Red Book* could produce substantial savings to the Department of Health and Human Services (HHS). We hope that this edition will prove useful to departmental decisionmakers, the administration, and the Congress in their continuing efforts to contain costs and improve program efficiency at HHS.

Department of Health and Human Services

HHS promotes the health and welfare of Americans and provides essential services to people of every age group. The Department's major operating divisions are briefly described below:

- The Centers for Medicare and Medicaid Services (CMS) administers the Medicare and Medicaid programs, as well as the State Children's Health Insurance Program (CHIP) and the new Medicare Part D and Medicare Advantage programs. These programs, which account for over 80 percent of the HHS budget, provide medical care coverage for the elderly, the disabled, the poor, and children whose families earn too much to qualify for Medicaid but too little to afford private coverage.
- The public health agencies include the National Institutes of Health, the Food and Drug Administration, the Centers for Disease Control and Prevention, the Health Resources and Services Administration, the Indian Health Service, the Agency for Toxic Substances and Disease Registry, the Agency for Healthcare Research and Quality, and the Substance Abuse and Mental Health Services Administration. They promote biomedical research and disease cure and prevention; ensure the safety and efficacy of marketed food, drugs, and medical devices; and conduct

other activities designed to ensure the general health and safety of American citizens.

- The Administration for Children and Families provides Federal direction and funding for State-administered programs designed to promote stability, economic security, responsibility, and self-support for the nation's families, including a variety of social service programs.
- The Administration on Aging awards grants to States for establishing comprehensive community-based systems that, through services such as congregate and home-delivered meals and in-home care and family caregiver support, assist in maintaining the dignity and quality of life of older Americans and their families.

Significant OIG Activities

Over the years, OIG findings and recommendations have contributed to many significant reforms and substantial savings in departmental programs. In fiscal year (FY) 2003, for example, policy and procedural changes resulting from audits, investigations, and inspections achieved almost \$23 billion in savings. Such changes included capping the Medicaid upper payment limit, establishing a Medicare prospective payment system and consolidated billing for skilled nursing facilities, and restructuring Medicare home health payments.

Organization of the Red Book

The *Red Book* has **two major sections**. Recommendations made since the last edition was published are included in the first section; previously published recommendations can be found in the second.

For each recommendation, we summarize the current law, the reason that action is needed, the estimated savings that would result from taking the recommended action, the status of actions taken, and the report number and date. In addition, the type of action needed (legislative, regulatory, or procedural) is indicated. Recommendations for proposed legislation are removed from the *Red Book* once the law has been fully enacted. On regulatory and procedural issues, recommendations are removed when the action has been substantially completed.

Each final report, including the full text of comments from the cognizant agency, is available upon request or on the Internet at <http://oig.hhs.gov>. Each report also includes an appendix detailing OIG's methodology for estimating cost savings; we encourage the reader interested in a particular proposal to review the report.

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New Recommendations

End Stage Renal Disease

Limit Payment Under Method II for Continuous Ambulatory Peritoneal Dialysis to Method I Rates

Current Law: Section 1881(b)(7) of the Social Security Act limits payment under any method other than the composite rate (referred to as Method I) to no more than 130 percent of hospital-based dialysis facility rates for continuous cycling peritoneal dialysis. Under Method I (or the composite rate), dialysis facilities receive a set payment for each dialysis treatment and related supplies. Alternately, under Method II a beneficiary may elect to receive all dialysis supplies from a durable medical equipment supplier to perform self-dialysis. At 42 CFR § 414.330(c)(2), payment limits for continuous cycling peritoneal dialysis under Method II are established at 130 percent of the national median amount for hospital-based facilities.

Proposal (✓Regulatory): CMS should change the regulation to limit payment for Method II continuous cycling peritoneal dialysis kits to no more than Method I.

Reason for Action: Medicare pays for hemodialysis and continuous ambulatory peritoneal dialysis at the same rate, whether payment is made to a dialysis facility under the composite rate or to a durable medical equipment supplier under Method II. Continuous cycling peritoneal dialysis is paid at this same rate when payment is made to a dialysis facility, but durable medical equipment suppliers may bill up to 130 percent of this rate.

Savings (in Millions):

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
\$12.2	\$12.2	\$12.2	\$12.2	\$12.2

Status: CMS does not concur with this recommendation, believing that Congress intended that durable equipment suppliers should have a higher payment limit. CMS has eliminated billing for kits under Method II and requires suppliers to itemize supplies, which are reimbursed based on reasonable charges up to a monthly payment limit.

Report:

OEI-07-01-00570 (final report, 5/03)

Durable Medical Equipment

Reduce Medicare Part B Payments for Power Wheelchairs

Current Law: Medicare Part B classifies certain items of durable medical equipment, such as power wheelchairs, as capped rental items. Medicare pays for the rental of these items for a period of continuous use not to exceed 15 months. Beneficiaries have the option of purchasing a power wheelchair within the first month of use.

Proposal (✓Regulatory): CMS should create a new coding system for K0011 power wheelchairs (standard-weight frame motorized/power wheelchairs with programmable control parameters for speed adjustment, tremor dampening, acceleration control, and braking) that accounts for the variety in models and prices for power wheelchairs and/or determine whether an inherent reasonableness review for K0011 power wheelchairs is appropriate.

Reason for Action: We compared Medicare's CY 2003 median fee schedule amount for K0011 power wheelchairs to the median price available to the general public, the median wholesaler price, and the median price negotiated by suppliers with manufacturers and distributors. The Medicare reimbursement amount for K0011 power wheelchairs exceeded the median prices from the three sources reviewed by 37 to 242 percent. While there was a wide range in price, 94 percent of the prices were less than the Medicare reimbursement amount.

Savings (in Millions):

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
\$224	\$224	\$224	\$224	\$224

Status: CMS will consider using its inherent reasonableness authority when it develops, in accordance with statute and regulations, written procedures for conducting these reviews to reduce the reimbursement amount for K0011 power wheelchairs. Additionally, CMS is working with a coding panel to develop a new set of codes that best describes the wheelchairs on the market and published new codes for wheelchair cushions in July 2004.

Report:

OEI-03-03-00460 (final report, 4/04)

Improve Compliance With Medicare Coverage Criteria for Power Wheelchairs

Current Law: Medicare Part B classifies certain items of durable medical equipment, such as power wheelchairs, as capped rental items. Medicare pays for the rental of these items for a period of continuous use not to exceed 15 months. Beneficiaries have the option of purchasing a power wheelchair within the first month of use.

Proposal (✓Regulatory): CMS should improve compliance with Medicare’s coverage criteria for power wheelchairs by (1) requiring durable medical equipment regional carriers to revise current coverage policies for power wheelchairs to include specific information about the medical conditions for which Medicare will cover this item, (2) conducting frequent reviews of claims for K0011 power wheelchairs (standard-weight frame motorized/power wheelchairs with programmable control parameters for speed adjustment, tremor dampening, acceleration control, and braking), and (3) educating ordering physicians and beneficiaries about power wheelchair coverage criteria.

Reason for Action: We found that most claims for K0011 wheelchairs reviewed did not meet Medicare’s coverage criteria. We also identified a number of other problems with Medicare claims for K0011 power wheelchairs, including missing and incomplete supporting documentation and equipment that was not used by Medicare beneficiaries.

Savings (in Millions):

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
\$178	\$178	\$178	\$178	\$178

Status: CMS generally concurred with our recommendations and is taking steps to improve compliance with Medicare’s coverage criteria for power wheelchairs. CMS is requiring the durable medical equipment regional carriers to develop and implement consistent medical review strategies. In addition, CMS has prepared an educational brochure that provides physicians and suppliers with information regarding coverage policy. A similar brochure, prepared for beneficiaries, contains information regarding Medicare and durable medical equipment regional carriers coverage policy.

Report:

OEI-03-03-00600 (final report, 3/04)

Reduce Medicare Part B Payments for Enteral Nutrition at Home

Current Law: Medicare covers enteral nutrition therapy, commonly called tube feeding, for beneficiaries who cannot swallow due to a permanent medical problem or an impairment of long and indefinite duration. Medicare Part B coverage of enteral nutrition therapy is provided under the prosthetic device benefit for beneficiaries residing at home, or in a nursing facility when the stay is not covered by Medicare Part A.

Medicare groups enteral nutrition formula products into seven classes based on their composition. Products falling within these classes are identified by one of seven Healthcare Common Procedure Codes for reimbursement purposes. A wide variety of enteral nutrition formulas are grouped under Category I (code B4150).

Proposal (✓Regulatory): CMS should consider using the inherent reasonableness authority to reduce the Medicare reimbursement amount for Category I enteral nutrition formulas.

Reason for Action: We compared the amount Medicare reimburses for Category I enteral nutrition formulas to prices available to the supplier community. We found that the amount Medicare reimburses for Category I formulas exceeded median contract prices available to suppliers from the sources we reviewed by 70 to 115 percent.

Savings (in Millions):

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
\$82	\$82	\$82	\$82	\$82

Status: CMS concurs with our recommendation, but must wait to initiate inherent reasonableness reviews until written procedures for conducting these reviews are developed according to statute and regulation.

Report:

OEI-03-02-00700 (final report, 2/04)

Other Medicare Reimbursement

Encourage Least Costly Alternative Policies for Lupron Reimbursement

Current Law: Medicare Part B does not currently pay for over-the-counter or most outpatient prescription drugs, although the new Medicare Prescription Drug and Improvement and Modernization Act of 2003 will implement a new prescription drug benefit. At the time of the study, Medicare reimbursed for Lupron at 95 percent of the average wholesale price, but under the new law, as of January 2004, the reimbursement decreased to 81 percent of average wholesale price. Carriers have discretion to use a least costly alternative policy when reimbursing for drugs. This policy requires that carriers not cover the additional cost of a more expensive product if a clinically comparable product costs less.

Proposal (✓*Procedural*): CMS should recommend that all Medicare carriers apply a least costly alternative policy to Lupron.

Reason for Action: Our review of 2002 drug claims identified \$40 million in potential savings if 10 carriers not now using a least costly alternative implemented such a policy.

Savings (in Millions):

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
\$4	\$4	\$4	\$4	\$4

Status: CMS partially concurred, agreeing to facilitate communication between carriers that have adopted a least costly alternative policy and those that have not. However, CMS also stated that they do not generally influence the application of local medical review policies in specific circumstances.

Report:

OEI-03-03-00250 (final report, 1/04)

Reduce Medicare Payments to Ambulatory Surgical Centers for Intraocular Lenses

Current Law: Section 1833(i)(2)(A)(iii) of the Social Security Act requires Medicare payments to ambulatory surgical centers for intraocular lenses to be “reasonable and related to the cost” of the lens.

Proposal (✓Regulatory): CMS should reduce Medicare payments to ambulatory surgical centers for intraocular lenses in a manner that takes into account the different types and cost of the lenses.

Reason for Action: Payment is currently set at \$150 per lens for all types of lenses except for certain “new technology intraocular lenses.” We found that while the average cost of a lens was \$90.30, this varied significantly by the type of material used to make the lens. Soft acrylic lenses averaged a cost of \$124.77, silicone lenses averaged \$69.37, and polymethyl methacrylate averaged \$39.10.

Savings (in Millions):

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
\$34.8	\$34.8	\$34.8	\$34.8	\$34.8

Status: The Medicare Prescription Drug, Improvement and Modernization Act of 2003 requires CMS to implement a revised payment system for ambulatory surgical centers between January 2006 and January 2008. CMS will consider our recommendation when devising that payment system.

Report:

OEI-06-02-00710 (final report, 3/04)

Identify and Collect Overpayments for Home Health Services Preceded by a Hospital Discharge

Current Law: Under Medicare regulations, home health agencies are eligible for a higher payment for services provided to beneficiaries who were not discharged from an inpatient hospital within 14 days of receiving home health services.

Proposal (✓*Procedural*): CMS should require that its regional home health intermediaries (1) recover the overpayments identified by OIG, (2) identify and collect overpayments made following the period of OIG’s review, and (3) educate home health agencies to ensure that they accurately code prior beneficiary discharge data on the patient assessment forms.

Reason for Action: Our reports to each of the regional intermediaries estimated that in FY 2001, nearly \$23 million in overpayments were made because home health agencies did not properly code prior hospital discharges on the beneficiaries’ assessment forms.

Savings (in Millions):

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
\$23	\$23	\$23	\$23	\$23

Status: The regional home health intermediaries generally agreed with our recommendations. CMS has instructed them to collect the overpayments. CMS issued instructions dated October 23, 2003 to the regional home health intermediaries to implement, by April 1, 2004, prepayment edits to identify prior hospital discharges that were not identified by the home health agencies. The same instruction outlines a process for postpayment recoveries for FYs 2002 and after.

Report:

A-01-03-00500 (final report 7/03)

A-04-03-00018 (final report 2/04)

A-09-03-00042 (final report 2/04)

A-07-03-04021 (final report 3/04)

Medicaid Reimbursement

Declare That Medicaid Payments Returned by Public Providers Are Refunds

Current Law: Since the inception of the Medicaid program, the Federal Government and the States have shared in its costs. States pay medical providers who furnish care and services to Medicaid-eligible individuals. The Federal Government pays the States its share of these medical assistance payments according to a defined formula, which yields the Federal medical assistance percentage. This percentage ranges from 50 percent to 83 percent, depending on the State's per capita income.

Proposal (✓*Legislative*): CMS should propose legislation to require that Medicaid payments returned by public providers to the State are declared a refund to be used to offset or credit the Federal financial participation generated by the original payment.

Reason for Action: We believe that the return to the State of Medicaid payments by public providers, often through the use of intergovernmental transfers, is indicative that the States did not incur health care expenditures for which Federal matching funds were claimed. Currently, the States have developed financial mechanisms involving intergovernmental transfers to obtain Federal funds without committing their share of the required matching funds.

Savings (in Millions):

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
TBD	TBD	TBD	TBD	TBD

**CMS's April 2004 testimony before the House Energy and Commerce Committee indicated that an estimated \$23 billion in Medicaid savings over 10 years was possible by declaring these returned funds as credits.*

Status: In its initial response to our report, CMS indicated that this proposal required further review. As noted above, CMS's congressional testimony indicated that it now supports declaring these returned funds as credits or refunds to offset the original State payment. The Federal share would then be calculated based on the net Medicaid payment retained by the provider.

Report:

A-03-00-00216 (final report, 9/01)

Establish Definitive Guidance on Calculating Upper Payment Limits and Use Facility-Specific Limits Based on Actual Costs

Current Law: In a final rule published in January 2001, CMS revised the Medicaid upper payment limit regulations to provide for three separate aggregate upper limits—one each for private, State, and non-State government-owned facilities. The regulations stipulate that aggregate State payments for each class of service (for example, inpatient hospital services) may not exceed a reasonable estimate of the amount the State would have paid under Medicare payment principles.

Proposal (✓*Legislative*, ✓*Regulatory*, ✓*Procedural*): CMS should provide States with definitive guidance on calculating the upper payment limit so that a uniform standard is applied to all States. This guidance could possibly be provided to States through a letter to the Medicaid Directors. We also believe that States should use facility-specific upper payment limits that are based on actual cost report data.

Reason for Action: Our audits have shown that States applied various methods to compute the Medicare upper payment limit. In some cases, they used routine cost limits; other States used various prospective payment system values. Allowing States this flexibility in complying with Medicaid payment principles has resulted in significant differences in the calculation of the State funding pools used in applying the upper payment limit provisions.

Savings (in Millions):

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
TBD	TBD	TBD	TBD	TBD

Status: CMS partially concurred with our recommendations. It agreed that it should provide more guidance on calculating the upper payment limit. CMS did not agree, at this time, to limit the upper payment limit calculation to a facility-specific value based on Medicaid costs. CMS wished to allow States additional flexibility to better respond to the unique challenges of maintaining access to services but agreed to reconsider this if States continued to manipulate Federal Medicaid funding.

Report:

A-03-00-00216 (final report, 9/01)

Review Medicaid Reimbursement for Mental Health Drugs

Current Law: Title XIX of the Social Security Act established Medicaid as a jointly funded, Federal-State health insurance program. Medicaid plays a fundamental role in the provision of prescription drugs to over 42 million low-income and disabled beneficiaries, spending an estimated \$20 billion in 2001. Expenditures for drugs used for the treatment of mental disorders are among the fastest-rising costs for Medicaid, representing an estimated 20 percent, or \$4 billion, of Medicaid’s total drug payment. Title XIX requires States to provide methods and procedures to assure that payments are “consistent with efficiency, economy, and quality of care.” CMS exercises this control in two ways: by placing aggregate limits on pharmacy reimbursements and collecting statutorily defined manufacturer rebates. In addition, Section 340B of the Public Health Service Act authorizes a Federal discount program for outpatient drugs purchased by certain Federal grantees and public hospitals. The formula for determining the discounted drug prices is based on the Medicaid drug rebate amount.

Proposal (✓Regulatory, ✓Procedural): CMS should review the current reimbursement methodology and work with States to find a method that more accurately estimates pharmacy acquisition cost.

Reason for Action: Medicaid pays up to 29 percent more than other Federal Government drug discount programs for 25 mental health drugs we reviewed. Medicaid would have saved \$47 million if it had been able to pay prices equivalent to the Federal Supply Schedule prices and \$126 million if it had paid prices equal to the “Big 4” (Department of Defense, Veterans Administration, Public Health Services, and United States Coast Guard) prices. In comparison to the Federal ceiling prices and those of the 340B Drug Discount Program, Medicaid would have saved \$116 and \$66 million, respectively, for the 25 drugs.

Savings (in Millions):

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
\$126	\$129	\$132	\$136	\$140

Status: Some unknown portion of the costs for these drugs will be addressed by the implementation of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 for those beneficiaries who are dually eligible for Medicare and Medicaid. It is unclear at this time what action CMS may take in regards to the cost of these drugs.

Report:

OEI-05-02-00080 (final report, 8/03)

Encourage States to Collect Rebates on Physician-Administered Drugs, Especially Single-Source Drugs

Current Law: Under section 1927 of the Social Security Act, State Medicaid agencies receive manufacturer rebates for drugs under the Medicaid Drug Rebate Program. In order to receive rebates, States identify the drugs by national drug codes and provide unit and payment information to the manufacturer. If States do not require the use of national drug codes for physician-administered drugs, identifying drugs is difficult.

A single-source drug is a brand-name drug that is manufactured under a patent and has no competing products. Single-source drugs are more likely to have only one national drug code and are more easily matched to a procedure code than multiple-source drugs.

Proposal (✓*Procedural*): CMS should continue to encourage States to collect rebates on physician-administered drugs, especially single-source drugs.

Reason for Action: Medicaid could have saved an additional \$37 million on rebates for physician-administered drugs in 2001. Single-source drugs represented \$30 million of these potential savings. States should either use national drug codes instead of procedure codes, or use crosswalks to link procedure codes to national drug codes for single-source drugs.

Savings (in Millions):

<u>FY1</u>	<u>FY2</u>	<u>FY3</u>	<u>FY4</u>	<u>FY5</u>
\$37	\$37	\$37	\$37	\$37

Status: CMS agrees that States should be encouraged to collect rebates on physician-administered drugs. Specifically, CMS has developed a crosswalk for States to use to convert procedure codes to national drug codes for rebate identification purposes.

Report:

OEI-03-02-00660 (final report, 4/04)

Address and Resolve Excessive Medicaid Disproportionate Share Hospital Payments

Current Law: Section 13621 of the Omnibus Budget Reconciliation Act of 1993 amended section 1923 of the Social Security Act to limit disproportionate share hospital (DSH) payments to the hospital's cost of incurred uncompensated care. Costs of uncompensated care were limited to the costs of medical services provided to Medicaid and uninsured patients less payments received for those patients excluding Medicaid DSH payments.

Proposal (✓Regulatory, ✓Procedural): States should work with CMS to address and resolve DSH payments made in excess of hospitals' actual incurred uncompensated care costs. Also, consistency is needed in State plans with regard to compliance with Federal laws and regulations and what constitute allowable costs to be included in the calculation of DSH limits.

Reason for Action: Audits in 10 States found that while DSH payments were generally in accordance with State plans, DSH payments exceeded the hospital-specific limits. All 10 States had problems administering their DSH programs. CMS did not provide comprehensive guidance to the States for use in developing State plans and establishing controls over the DSH programs. To date, \$336 million (Federal share) has been recommended for recovery from the States. We also recommended that the States work with CMS to address and resolve an additional \$522 million Federal share in DSH payments made in excess of hospital specific limits.

Savings (in Millions):

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
TBD	TBD	TBD	TBD	TBD

Status:

CMS has begun action in individual States to recover overpayments. It is currently developing a regulation on the Medicaid DSH program. We will provide CMS with a summary report on our work in this area with additional recommendations on only paying actual costs of uncompensated care.

Report:

A-06-00-00058 (final report, 6/01)	A-03-01-00222 (final report, 4/03)
A-06-00-00026 (final report, 6/01)	A-03-01-00226 (final report, 5/03)
A-07-01-02089 (final report, 5/02)	A-09-02-00054 (final report, 5/03)
A-07-01-02093 (final report 8/02)	A-09-02-00071 (final report, 5/03)
A-09-01-00098 (final report, 9/02)	A-05-01-00058 (draft report, 6/03)
A-09-01-00085 (final report, 9/02)	A-05-01-00059 (draft report, 7/03)
A-10-01-00001 (final report, 10/02)	A-05-01-00099 (draft report, 7/03)
A-04-01-02006 (draft report, 1/03)	A-05-01-00102 (draft report, 7/03)
A-06-01-00041 (final report, 2/03)	A-05-01-00087 (final report, 3/04)
A-03-01-00221 (final report, 4/03)	

Ensure Compliance With Requirements for Medicaid School-Based Health Services

Current Law: Section 1903(c) of the Social Security Act was amended in 1988 to allow Medicaid payment of covered services for children under the Individuals with Disabilities Education Act. The Act requires States to provide appropriate special education and related services to children with disabilities or special needs. The Social Security Act also permits Federal financial participation in the administrative costs of Medicaid activities performed in schools.

Proposal (✓Procedural): CMS should recover the overpayment identified during our audits of school-based claims. In addition, States should disseminate CMS guidance and other information to the local education agencies in a timely manner, monitor local education agencies to ensure compliance with Federal and State requirements, and assist the local education agencies in developing written policies and procedures that require service providers to document all health services and to retain those records for review. States should refund overpayments to the Federal Government.

Reason for Action: OIG’s reviews of 13 States found large Medicaid overpayments for school-based health services and administrative claims. We estimated that one State improperly claimed \$172.6 million in Federal Medicaid funds for services that did not meet Federal and State requirements. Many of the services claimed lacked a referral by an appropriate medical professional or were not provided by or under the direction of a qualified speech-language pathologist. In the other State reviews, Federal overpayments totaled an estimated \$65.6 million. These unallowable claims generally occurred because States did not provide sufficient guidance to and oversight of local education agencies and rates were not developed in accordance with applicable Federal cost allocation requirements or CMS program guidelines.

Savings (in Millions):

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
TBD	TBD	TBD	TBD	TBD

Status: CMS has begun action in individual States to recover overpayments. We will provide CMS with a summary report on our work in this area with additional recommendations on only paying for actual Medicaid school-based services.

Report:

A-04-00-02161 (final report, 11/01)	A-01-02-00006 (final report, 5/03)
A-10-01-00011 (final report, 5/02)	A-01-02-00009 (final report, 7/03)
A-10-01-00006 (final report, 8/02)	A-02-03-01008 (draft report, 7/03)
A-06-01-00077 (final report, 10/02)	A-10-02-00008 (final report, 7/03)
A-02-02-01018 (final report, 12/02)	A-05-02-00049 (final report, 12/03)
A-03-01-00224 (final report, 3/03)	A-06-02-00037 (final report, 1/04)
A-04-01-00005 (draft report, 3/03)	A-01-02-00014 (final report, 2/04)
A-05-02-00023 (final report, 3/03)	A-02-02-01030 (final report, 2/04)
A-02-02-01022 (final report, 4/03)	A-07-02-02099 (final report, 2/04)
A-06-01-00083 (final report, 4/03)	A-01-03-00010 (draft report, 3/04)

Health Resources and Services Administration

Eliminate Excessive Costs in the 340B Drug Discount Program

Current Law: Section 340B of the Public Health Service Act (the PHS Act) created the 340B Drug Discount Program to lower drug prices for more than 10,500 entities, including community health centers, public hospitals, and various Federal grantees. Pharmaceutical manufacturers calculate the 340B discount using a specified formula and must sell their products at or below this price to continue to receive reimbursement from the Medicaid program. The Health Resources and Services Administration’s (HRSA) Office of Pharmacy Affairs administers the program for the 10,500 enrolled entities, which were estimated to spend \$3.4 billion on drugs in 2003.

Proposal (✓Regulatory, ✓Procedural, ✓Legislative): HRSA should take four steps to strengthen its administration of the 340B Drug Discount program: spot check entity-level transactions; seek legislative authority to establish penalties for violations of the PHS Act; provide covered entities with pricing data to approximate the discount they are entitled to; and verify CMS’s 340B ceiling price against the manufacturers' calculation of the ceiling price.

Reason for Action: Despite the requirements of the PHS Act, 31 percent of the sampled prices exceeded the 340B discount price. For the month of September 2002, 340B entities spent an estimated \$269 million and were overcharged \$41.1 million. These amounts are estimated reductions in grantee expenditures for drug purchases. The grantees will have these amounts available for any of the services they provide. Federal outlays will not be reduced by these amounts.

Savings (in Millions):

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
TBD*	TBD*	TBD*	TBD*	TBD*

** The cost savings estimates identified in the “Reason for Action” represent savings to federally-supported covered entities. Though there will be associated indirect savings to HHS as well, we cannot and have not attempted to quantify such savings.*

Status: HRSA indicates that plans have been formulated to address many of the shortcomings noted by the OIG’s final reports. At this time, these plans are being reviewed within the Department. HRSA also states that the Office of Pharmacy Affairs is working with the OIG, the Justice Department, and CMS to develop plans to strengthen the integrity of the 340B Program.

Report:

OEI-05-02-00070 (final report, 6/04)

Previous Recommendations

Hospitals

Continue Mandated Reductions in Hospital Capital Costs

Current Law: In October 1991, CMS began a 10-year transition period for paying inpatient hospital capital-related costs under a prospective payment system. The rates are based on historical costs, less a mandated reduction of 7.4 percent under the Omnibus Budget Reconciliation Act of 1993.

Proposal (✓*Legislative*): CMS should (1) seek legislative authority to continue mandated reductions in capital payments beyond FY 1995 and (2) determine the extent that capital payment reductions are needed to fully account for hospitals' excess bed capacity and report the percentage of reduction to the Congress.

Reason for Action: Hospital capital costs soared during the first 5 years of the prospective payment system for inpatient hospital costs, despite low bed occupancy. The Medicare system of reimbursing capital costs on a pass-through basis (*i.e.*, reimbursed outside the diagnosis-related group (DRG)) was a major reason for this increase. Paying capital costs prospectively, as required by regulation, should assist in curbing escalating costs. However, the prospective rates are based on historical costs that are inflated because (1) excess capacity in the hospital industry has caused more capital costs to be incurred than economically necessary and (2) inappropriate elements, such as charges for depreciation on federally funded assets, are included in the historical costs.

Savings (in Millions):

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
TBD	TBD	TBD	TBD	TBD

Status: CMS does not agree with our recommendation. CMS believes that section 1886(g)(1)(B)(iv) of the Act, which states that the Secretary may provide for an adjustment for occupancy rate, is only intended to provide for an adjustment to capital prospective payment system payments based on a hospital's current occupancy rate. Although the Balanced Budget Act of 1997 reduced capital payments, it did not include the effect of excess bed capacity and other elements included in the base-year historical costs. The President's FY 2001 budget proposed reducing capital payments and saving \$630 million from FY 2001 through FY 2005.

Report:

A-09-91-00070 (final report, 4/92)

A-14-93-00380 (final report, 4/93)

More Accurately Reflect Base-Year Costs in Prospective Payment System's Capital Cost Rates

Current Law: Under section 1886(d) of the Social Security Act, the Medicare program pays for the operating costs attributable to hospital inpatient services under a prospective payment system. The system pays for care using a predetermined specific rate for each discharge. Public Law 100-203 required the Secretary of Health and Human Services to establish a prospective payment system for capital costs for cost reporting periods beginning in FY 1992.

Proposal (✓*Legislative*): CMS should (1) consider seeking legislation to reduce payment rates by 7.5 percent to more accurately reflect costs of the base year used for the capital cost prospective payment system and (2) continue to monitor the most current data and make any necessary further adjustments to the base rate.

Reason for Action: While CMS took care to devise and implement an equitable prospective payment system for capital costs, some future cost items had to be estimated. A few years later, when actual data were available, we compared CMS's estimates with the actual data and found, in some cases, that the estimates were too high. A 7.5-percent reduction would correct all forecasting estimates that CMS had to make in arriving at an anticipated rate to implement the capital cost prospective payment system. The total effect of overpayments in relation to costs used as the basis for this system gradually increased from 1996 until the system was fully implemented in 2002.

Savings (in Millions):

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
TBD	TBD	TBD	TBD	TBD

Status: CMS agreed that the capital rate reflected an overestimation of base-year costs, and the Balanced Budget Act of 1997 provided for a reduction in capital payments for 1998-2002. CMS is continuing to monitor current capital payment and cost data to determine whether additional adjustments are warranted.

Report:

A-07-95-01127 (final report, 8/95)

Collect Overpayments for Prospective Payment System Transfers Incorrectly Reported as Discharges

Current Law: In implementing the Medicare Part A prospective payment system, CMS issued 42 CFR 412.4, which sets forth the basic rules for patient transfers. Section 412.4(b) states that a discharge of a hospital inpatient is considered to be a transfer if the discharge is made from a hospital to another hospital that is paid under the prospective payment system or that is excluded from the payment system because of participation in an approved statewide cost control program. In addition, section 412.4(b)(2) indicated that a discharge from one inpatient area to another inpatient area of a prospective payment system hospital constitutes a transfer. In its final rule on IPPS dated August 1, 2003, CMS expanded the transfer policy to include all patients who are admitted to another IPPS hospital on the same day they are transferred from an IPPS hospital. CMS also deleted 412(b)(2) from the definition of a transfer.

Proposal (✓Procedural): CMS should issue instructions to and work with fiscal intermediaries to collect the \$163.9 million in potential overpayments identified for the period January 1, 1992 to June 30, 2000. CMS should also issue clarifying instructions to intermediaries and hospitals regarding prospective payment system transfers.

Reason for Action: For a number of years, OIG and CMS have been concerned about hospitals' incorrect reporting of prospective payment system transfers as discharges and fiscal intermediaries' failure to detect and correct these errors. Previous OIG and joint OIG/CMS efforts in this area resulted in over \$219 million in recoveries.

Savings (in Millions):

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
TBD	TBD	TBD	TBD	TBD

Status: CMS concurred with our recommendation to collect potential overpayments but stated that it would initially limit the recovery effort to the last 4 years to comply with the cost report reopening period designated in 42 CFR 405.750. In September 2001, CMS advised the intermediaries to recover overpayments on the claims we identified that were 4 years old or less from the date of initial determination (bill processing date). As of January 27, 2004, 37 intermediaries reported recoveries totaling \$23.3 million.

Medicare regulations allow CMS to reopen claims up to 4 years after the date of initial determination upon establishment of good cause and at any time when the payment decision involves fraud or similar fault. CMS and OIG are conducting further reviews to determine whether any of the cases that occurred more than 4 years ago merit reopening under the regulations.

Report:

A-06-00-00041 (final report, 11/01)

Reduce the Prospective Payment System Adjustment Factor for Indirect Medical Education Costs

Current Law: Since the inception of the Medicare prospective payment system, indirect medical education payments have been paid only to teaching hospitals to address the presumably higher costs incurred by these hospitals. CMS and the Congress determined the indirect medical education adjustment factor. Using historical data and regression analysis, CMS compared costs per case in teaching and nonteaching hospitals and determined that operating costs in hospitals with teaching programs increased approximately 5.79 percent for every 0.1 resident physician per hospital bed compared with hospitals without teaching programs. A congressional mandate required CMS to double the adjustment factor under the prospective payment system to 11.59 percent. The Consolidated Omnibus Budget Reconciliation Act of 1985 reduced the indirect medical education adjustment factor from 11.59 percent to 8.1 percent for discharges occurring on or after May 1, 1986 and before October 1, 1988. The Omnibus Budget Reconciliation Act of 1987 further modified the adjustment by reducing it to approximately 7.7 percent for each 0.1 in the ratio of interns and residents to beds.

Proposal (✓*Legislative*): CMS should continue to pursue legislation to reduce the indirect medical education adjustment factor to the level supported by CMS empirical data, and further studies should be made to determine whether different adjustment factors are warranted for different types of teaching hospitals.

Reason for Action: Our extensive analytical work showed that teaching hospitals earned substantial profits. In addition, a Prospective Payment Assessment Commission report found that the indirect medical education adjustment substantially overlapped with the disproportionate share adjustment at teaching hospitals and that these payments were a major source of revenue for some hospitals.

Savings (in Millions):

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
TBD	TBD	TBD	TBD	TBD

Status: CMS agreed with our recommendation. In addition, the Balanced Budget Act of 1997, as amended by the Balanced Budget Refinement Act of 1999, reduced the indirect medical education adjustment factor from 7.7 percent in FY 1997 to 5.5 percent in 2002 and thereafter. Section 502 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 increased the IME adjustment factor to 6 percent during the second half of FY 2004, to 5.79 percent in FY 2005, and to 5.58 percent in FY 2006, before reducing the factor to 5.38 percent in FY 2007 and returning to 5.5 percent in FY 2008 and thereafter. We believe the factor should be further reduced to eliminate any overlap with the disproportionate share adjustment. We plan to further review this area by analyzing the effect the reduction in the number of beds in hospitals has had in the payment of indirect medical education payments.

Report:

A-07-88-00111 (final report, 9/89)

Revise Graduate Medical Education Payment Methodology

Current Law: Section 9202 of the Consolidated Omnibus Budget Reconciliation Act of 1985 and section 9314 of the Omnibus Budget Reconciliation Act of 1986 changed the way Medicare reimburses hospitals for the direct costs of graduate medical education. Under the revised methodology, costs are reimbursed on a “hospital-specific” prospective payment basis, which is based on a hospital’s graduate medical education costs per resident in the cost reporting period that began during Federal FY 1984.

Proposal (✓*Legislative*, ✓*Regulatory*): CMS should (1) revise the regulations to remove from a hospital's allowable graduate medical education base-year costs any cost center with little or no Medicare utilization and (2) submit a legislative proposal to compute Medicare’s percentage of participation under the former, more comprehensive system.

Reason for Action: CMS estimated that the revised graduate medical education methodology would result in substantial Medicare savings. Our review indicated that Medicare costs under this methodology could actually increase because of two factors. First, the revised system allows hospital cost centers with little or no Medicare patient utilization to receive increased importance in the calculation of graduate medical education reimbursement. Second, the Medicare patient load percentage used to compute Medicare’s share of these costs is based on inpatient data only and is higher than Medicare’s overall share of graduate medical education costs as determined under the previous method, which also included ancillary and outpatient data.

Savings (in Millions):

	<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
Factor 1	\$ 39.2	\$ 39.2	\$ 39.2	\$ 39.2	\$ 39.2
Factor 2	125.6	125.6	125.6	125.6	125.6
Combined*	157.3	157.3	157.3	157.3	157.3

**When the two proposed changes are handled as one combined calculation, the savings are less than those from calculating the effect of the changes separately.*

Status: CMS did not concur with our recommendations. Although the Balanced Budget Act of 1997 and the Balanced Budget Refinement Act of 1999 contained provisions to slow the growth in Medicare spending on graduate medical education, we continue to believe that our recommendations should be implemented and that further savings can be achieved.

Report:

A-06-92-00020 (final report, 4/94)

Modify Payment Policy for Medicare Hospital Bad Debts

Current Law: Under Medicare’s inpatient hospital prospective payment system, hospitals are reimbursed for inpatient services rendered to Medicare beneficiaries by a fixed payment amount based on a diagnosis-related group (DRG). However, bad debts related to unpaid Medicare deductible and coinsurance amounts are reimbursed separately as pass-through items (i.e., reimbursed outside the DRG) under reasonable cost principles, subject to a 30-percent reduction. Other provider types are entitled to have their bad debts reimbursed at this rate as well.

Proposal (✓Legislative): CMS should consider options including the elimination of a separate payment for bad debts, the limitation of bad debt payments to prospective payment system hospitals that are profitable in Medicare operations, and the inclusion of a bad debt factor in the DRG rates. CMS should seek legislative authority to further modify bad debt policies.

Reason for Action: CMS records showed that total Medicare hospital bad debts increased from \$366 million in FY 1993 to almost \$574 million in FY 1997. During this same period, hospitals continued to earn significant profits. Although regulations provide that hospitals must be able to establish that they made reasonable bad debt collection efforts, such efforts have often been less than adequate; hospitals have little incentive to aggressively collect the unpaid deductible and coinsurance amounts when Medicare pays these amounts.

Savings (in Millions):*

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
\$340	\$485	\$485	\$485	\$485

**Amounts total the savings shown in the President’s FY 2001 budget.*

Status: CMS does not agree with our proposal to include a bad debt factor in the DRG rates. In responding to our report, CMS agreed with the recommendation to include a bad debt factor in the DRG rates. The Balanced Budget Act of 1997 provided for some reduction of bad debt payments to providers. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 subsequently increased bad debt reimbursement. Currently, Medicare pays 70 percent of allowable bad debts. Additional legislative changes are required to implement the modifications we recommended.

Report:

A-14-90-00339 (final report, 6/90)

Prevent Overpayments Under Medicare’s Postacute Care Transfer Policy

Current Law: The Balanced Budget Act of 1997 required implementation of a transfer policy to treat discharges of beneficiaries in specified diagnosis-related groups to certain postacute care settings as transfers for purposes of computing payments to prospective payment system hospitals.

Proposal (✓*Procedural*): CMS should establish edits in the Common Working File to compare beneficiary inpatient claims potentially subject to the postacute care transfer policy with subsequent postacute claims.

Reason for Action: We estimated that for the initial 2-year period of the postacute care transfer policy, the Medicare program paid approximately \$116 million in excessive payments to prospective payment system hospitals as a result of these erroneously coded discharges. Our reviews indicated that the Common Working File had no controls or edits in place to prevent excessive payments to such hospitals for erroneously coded qualified discharges that are followed by postacute care.

Savings (in Millions):

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
\$61	\$61	\$61	\$61	\$61

Status: CMS concurred with our recommendations. Edits were recently implemented. We will continue our work to identify additional overpayments that occurred prior to the implementation of the edits and to ensure that the edits are working properly.

Report:

A-04-00-01210 (final report, 12/00)

A-04-00-02162 (final report, 2/01)

A-04-00-01220 (final report, 10/01)

A-04-02-07005 (final report, 4/03)

Recover Overpayments and Expand the Diagnosis-Related Group Payment Window

Current Law: Under the prospective payment system for inpatient hospital services, Medicare fiscal intermediaries reimburse hospitals a predetermined amount for inpatient services furnished to Medicare beneficiaries depending on the illness and its classification under a diagnosis-related group (DRG). Currently, separate payments for nonphysician outpatient services (such as diagnostic tests and laboratory tests) provided to a patient during the 3 days immediately preceding the patient’s admission are not permitted under the Omnibus Budget Reconciliation Act of 1990, section 4003.

Proposal (✓*Legislative*): CMS should propose legislation to expand the DRG payment window to at least 7 days immediately before the day of admission.

Reason for Action: Our review identified about \$83.5 million in admission-related nonphysician outpatient services rendered 4 to 7 days immediately before an inpatient admission. A subsequent review identified \$37 million in preadmission services provided to patients for 10 selected DRGs 4 to 14 days prior to admission. Since the intent of the prospective payment system has always been to include related services under one prospective payment, it would seem appropriate that the DRG payment window encompass a longer period.

Savings (in Millions):

Diagnostic services provided:

	<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
4-7 days	\$83.5	\$83.5	\$83.5	\$83.5	\$83.5
4-14 days*	37.0	37.0	37.0	37.0	37.0

**For 10 selected DRGs.*

Status: CMS did not concur with the recommendation and has not pursued a legislative proposal.

Report:

A-01-92-00521 (final report, 7/94)

A-01-02-00503 (final report, 8/03)

Adjust Base-Year Costs in the Prospective Payment System for Hospital Outpatient Department Services

Current Law: The Balanced Budget Act of 1997 required CMS to develop a prospective payment system for hospital outpatient department services. The Act required CMS to use 1996 hospital claim data and the most recent available cost report data to develop the rates.

Proposal (✓*Legislative*): CMS, in conjunction with OIG, should further examine the extent to which the base-period costs used in the prospective payment rate calculations included unallowable costs and improper payments. If this work reveals that excessive unallowable costs and improper payments were included in the calculations, appropriate adjustments should be made.

Reason for Action: We are concerned about the reliability of the claim and cost data that CMS used in the prospective payment rate calculations. Our prior audit work identified substantial unallowable costs in hospitals' Medicare cost reports and several areas of payment improprieties in Medicare reimbursement for outpatient department services. Since the prospective payment fee schedules and expenditure ceiling are based on prior Medicare outpatient reimbursement, we believe that the rates may be inflated and that hospitals will realize windfall profits at Medicare's expense.

Savings (in Millions):

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
TBD	TBD	TBD	TBD	TBD

Status: CMS agreed with our recommendations but no additional analysis has been done to examine the adequacy of base-year costs.

Report:

A-14-98-00400 (final report, 11/98)

Establish More Consistent Outpatient Surgery Rates That Reflect Only Necessary Costs

Current Law: The Medicare program covers hospital outpatient department services under the Medicare Supplemental Medical Insurance Program. Medicare reimbursement for services in these settings varies and has evolved over time. Hospital outpatient departments were historically reimbursed for services using a facility fee based on the lesser of costs or charges. In 1980, recognizing that some surgical procedures provided on an inpatient basis could be safely performed in less intensive and less costly settings, the Congress added coverage for services provided in ambulatory surgical centers (ASCs). In 2000, CMS implemented an outpatient prospective payment system for hospital outpatient services.

Proposal (✓*Legislative*): CMS should (1) seek authority to set rates that are consistent across sites and reflect only the costs necessary for the efficient delivery of health services and (2) remove the procedure codes that meet its criteria for removal from the ASC list of covered procedures.

Reason for Action: Our review of 424 ASC-approved procedure codes showed that Medicare paid an estimated \$1.1 billion more for services provided in settings with higher reimbursement in 2001. For similar procedures, CMS could have saved an estimated \$1 billion if the lower ASC rate had been used instead of the outpatient department rate. Likewise, CMS could have saved \$100 million if the lower outpatient department rate had been used instead of the ASC rate. Additionally, if CMS had removed 72 procedure codes meeting the criteria for removal from the ASC list, it could have saved almost \$8 million.

Savings (in Millions):

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
\$1,100	\$1,100	\$1,100	\$1,100	\$1,100

Status: CMS agrees to consider seeking authority to set rates that are consistent across sites as it develops its legislative program. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 requires CMS to implement a revised payment system for ambulatory surgical centers between January 2006 and January 2008. In a 2003 final rule, CMS removed from the list of approved ASC procedures 7 of the 72 codes that OIG cited as meeting the criteria for removal. As part of its biennial review of the ASC list, CMS is developing a proposed notice to update the list in 2005, and is considering the remaining codes recommended for deletion by OIG as part of this review. The proposed notice to update the ASC list is scheduled for publication in fall 2004.

Report:

A-14-89-00221 (final report, 3/91)
A-14-98-00400 (final report, 11/98)

OEI-09-88-01003 (final report, 5/89)
OEI-05-00-00340 (final report, 1/03)

Apply a 190-Day Lifetime Limit and a 60-Day Annual Limit on Medicare Inpatient Psychiatric Care

Current Law: Medicare limits inpatient care in psychiatric hospitals to 190 days during a beneficiary’s lifetime. When Medicare was established, inpatient psychiatric care was rendered, for the most part, in State psychiatric hospitals. The Congress apparently believed that long-term care of the mentally ill was generally a State responsibility. The delivery of inpatient psychiatric care has since expanded beyond psychiatric hospitals to general hospitals with distinct psychiatric units. The 190-day limit was not extended to these more costly general hospital units.

Proposal (✓*Legislative*): CMS should develop new limits to deal with the high cost and changing patterns of utilization of inpatient psychiatric services. A 60-day annual and a 190-day lifetime limit should be applied to all psychiatric care regardless of the place of service.

Reason for Action: The Medicare lifetime limit on psychiatric hospital care is no longer effective because of changed patterns of inpatient psychiatric care. Over 82 percent of the \$1.36 billion in program payments for inpatient psychiatric care is paid to general hospitals—where the lifetime limit does not apply. An annual limit on care, which has congressional precedence in a Department of Defense health care program, may be more acceptable than a lifetime limit. We believe that a 60-day annual limit on inpatient psychiatric services will produce significant savings over the current uneven application of the Medicare lifetime limit.

Savings (in Millions):

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
TBD	TBD	TBD	TBD	TBD

Status: CMS initially agreed with our findings but stated that further analysis would be required before any legislative changes could be supported. No action has been taken on this recommendation. We will consider reviewing this issue during FY 2005.

Report:

A-06-86-62045 (final report, 2/88)

Eliminate Provider-Based Designations or Improve Management and Oversight

Current Law: Hospitals often purchase a variety of other medical entities, such as physician practices, nursing facilities, and home health agencies. Under Medicare, hospitals may account for medical entities they own either as freestanding or as part of the hospital. If a hospital accounts for an entity as part of the hospital, it is referred to as a “provider-based” arrangement. This arrangement requires approval from CMS. Provider-based status increases costs for Medicare and its beneficiaries.

Proposal (✓*Legislative*, ✓*Procedural*): CMS should eliminate provider-based designations for hospital-owned physician practices and other entities. Otherwise, CMS should (1) seek legislation to impose penalties when hospitals fail to report ownership of other entities or bill for these entities inappropriately; (2) improve the data systems used to identify and track provider-based designations and clarify policies and procedures for tracking, approving, and evaluating provider-based status; and (3) require that all hospitals claiming provider-based status reapply.

Reason for Action: Our inspections found that hospitals purchased entities such as physician practices and billed for these entities as provider-based without CMS approval. CMS regional offices and fiscal intermediaries did not consistently follow CMS processes for review and approval of provider-based status and were frequently unaware of hospital practices in purchasing and billing for other entities. At issue is whether the site, or ownership of the site where the service is rendered, should dictate a higher payment by Medicare and the beneficiary.

Savings (in Millions):

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
TBD	TBD	TBD	TBD	TBD

Status: CMS published a final rule in August 2002, establishing strict criteria for obtaining provider-based status. Subsequently, the mandatory requirement for provider-based determinations was replaced with a voluntary attestation process. Providers are no longer required to apply for and receive a provider-based determination for their facilities prior to billing for services in those facilities as provider-based.

Report:

OEI-05-98-00110 (final report, 9/99)

OEI-04-97-00090 (final report, 8/00)

End Stage Renal Disease

Reduce Medicare End Stage Renal Disease Payment Rates

Current Law: The Omnibus Budget Reconciliation Act of 1981 established a prospective payment system for outpatient dialysis treatments under Medicare’s end stage renal disease (ESRD) program. To reimburse facilities for these treatments, CMS pays a composite rate per treatment based on audited median costs. In FY 1989, payments averaged \$125.05 per treatment for freestanding facilities and \$129.11 for hospitals.

Proposal (✓Legislative): CMS should reduce the payment rates for outpatient dialysis treatments to reflect current efficiencies and economies in the marketplace.

Reason for Action: Both 1985 and 1988 audited data justify a decrease in the payment rate. The 1985 data showed a median cost, including home dialysis costs, of \$108.19 per treatment. Even after considering the effect of home dialysis services, the in-facility costs decreased from 1980 to 1985 without a corresponding reduction in the prospective rates. In addition, our audit of the 1988 home office costs of a major chain of freestanding facilities showed that its costs decreased from \$117 per treatment in 1980 to \$89 in 1988. Due to the prominence of this chain, these audited costs have a significant impact on the median cost of dialysis treatments. We estimated that this chain was earning \$36 per treatment, a 29-percent profit margin for each treatment in 1988.

Savings (in Millions):*

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
\$22	\$22	\$22	\$22	\$22

**This estimate represents program savings of \$22 million for each dollar reduction in the composite rate based on 1988 data.*

Status: CMS agreed that the composite payment rates should reflect the costs of outpatient dialysis treatment in efficiently operated facilities, and the Balanced Budget Act of 1997 required the Secretary to audit the cost reports of each dialysis provider at least once every 3 years. The Balanced Budget Refinement Act of 1999 increased each composite rate payment for dialysis services furnished during 2000 by 1.2 percent above the payment for services provided on December 31, 1999. The Benefits Improvement and Protection Act of 2000 increased the payment rate for services provided in 2001 by 2.4 percent and required the Secretary to develop a composite rate that includes, to the maximum extent feasible, payment for clinical diagnostic laboratory tests and drugs that are routinely used in dialysis treatments but are currently separately billable by dialysis facilities. The Medicare Prescription Drug, Improvement and Modernization Act of 2003, title VI, section 623, increased the composite rate by 1.6 percent for 2005, restored the composite rate exception for pediatric facilities, and required the Secretary to establish a basic case-mix adjusted prospective payment system for dialysis services.

Report:

A-14-90-00215 (final mgmt. advisory report, 7/90)

Reduce the Epogen Reimbursement Rate

Current Law: Section 1881(b)(11)(B) of the Social Security Act provided that the Secretary of HHS may set an appropriate reimbursement level for the drug Epogen beginning January 1, 1995.

Proposal (✓*Legislative*, ✓*Regulatory*): The Secretary should consider reducing the current Medicare reimbursement rate for Epogen from \$10 to \$9 per 1,000 units administered. This reduction would result in savings to Medicare of approximately \$94 million and to its beneficiaries of approximately \$24 million per year.

Reason for Action: The current Epogen reimbursement rate of \$10 per 1,000 units administered exceeds the current purchase cost by approximately \$1. Of 105 providers randomly selected for review, 95 paid less than \$9 per 1,000 units of Epogen.

Savings (in Millions):

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
\$94	\$94	\$94	\$94	\$94

Status: CMS agreed and the Benefits Improvement and Protection Act of 2000 required the Secretary to develop a composite rate that includes, to the extent feasible, payment for laboratory tests and drugs that are routinely used in dialysis treatments but are now separately billable. The Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003 requires the Secretary to establish a case-mix adjusted Composite Rate for 2005 and conduct a demonstration of a bundled case-mix adjusted prospective payment system. MMA directs CMS to use the results of an OIG study on separately billable end state renal disease drug payments and costs to set the 2005 Composite Payment Rate. Section 623 of MMA requires that beginning January 1, 2005, payment for Epogen (as well as other end stage renal disease drugs) will be based on acquisition costs.

Report:

A-01-97-00509 (final report, 11/97)

Ensure That Claims for Ambulance Services for End Stage Renal Disease Beneficiaries Meet Coverage Guidelines

Current Law: The Medicare Part B benefit for ambulance service has very strict limits, as explained by CMS in the Medicare carrier manual, section 2120. The transport is not covered if it fails to meet the medical necessity requirement, even if it meets other requirements.

Proposal (✓Procedural): CMS should ensure that claims meet Medicare coverage guidelines.

Reason for Action: Seventy percent of transports involving dialysis in our sample did not meet Medicare guidelines for medical necessity because beneficiaries did not have conditions that contraindicated use of another type of transport on the date of ambulance service. These claims represented an estimated \$65.7 million in 1993. Almost two-thirds of the beneficiaries (63 percent) were clearly not bed-confined.

Savings (in Millions):

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
\$90	\$99	\$100	\$101	\$102

Status: CMS concurred with our recommendation. In January 1999, CMS issued a regulation that addressed ambulance payment issues and required physician certification of nonemergency transports. However, payments for this group of beneficiaries are particularly problematic; we plan to conduct additional analytical work on this topic.

Report:

OEI-03-90-02130 (final report, 8/94)

Modify Payment System for Ambulance Services for End Stage Renal Disease Beneficiaries

Current Law: Medicare Part B covers ambulance services under certain conditions. Ambulance transport must be reasonable and medically necessary. Ambulance company services and charges are represented by alphanumeric codes, which the Medicare program uses to analyze utilization and payments. Persons with ESRD are entitled to Medicare coverage under the 1972 amendments to the Social Security Act.

Proposal (✓*Legislative*, ✓*Regulatory*): CMS should ensure appropriate payment for services rendered and may consider using one or more of the following strategies: (1) establish a payment schedule for ambulance transport to maintenance dialysis, and set the fee lower than that paid for unscheduled, emergency transports; (2) negotiate preferred provider agreements with ambulance companies to provide scheduled transportation for ESRD beneficiaries; (3) use competitive bidding to establish a price for scheduled transports for ESRD beneficiaries or to select companies that agree to provide such services; (4) establish a rebate program for companies that routinely transport ESRD beneficiaries; and (5) provide an add-on to the composite rate that Medicare pays dialysis facilities, and allow the facilities to negotiate agreements with ambulance companies.

Reason for Action: The payment system does not take into account the routine, predictable nature of scheduled ambulance transports, nor does it take advantage of the lower costs associated with high-volume scheduled transports.

Savings (in Millions):

	<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
Lower estimate	\$ 4.9	\$ 6.0	\$ 7.3	\$ 8.9	\$10.9
Upper estimate	14.7	18.0	22.0	26.8	32.7

Status: CMS established codes for scheduled transport and required uniform use of national ambulance codes. In June 1997, CMS issued a notice of proposed rulemaking which would require physician certification of nonemergency transports. The Balanced Budget Act of 1997 authorized the establishment of a fee schedule for ambulance services which links payments to the type of services provided. In 1999, CMS clarified coverage rules for nonemergency transport, and in February 2002, CMS published a final rule establishing a fee schedule for ambulance services. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 increased Medicare payment rates for trips originating in a rural area.

Report:

OEI-03-90-02131 (final report, 3/94)

Durable Medical Equipment

Identify Medical Equipment/Supply Claims Lacking Valid, Active Unique Physician Identification Numbers

Current Law: The Consolidated Omnibus Budget Reconciliation Act of 1985 required CMS to establish unique physician identification numbers for all physicians who provide services to Medicare beneficiaries. Medicare requires that medical equipment and supplies be ordered by a physician or another qualified practitioner.

Proposal (✓Procedural): CMS should create edits to identify medical equipment and supply claims that do not have a valid and active physician identification number listed for the ordering physician.

Reason for Action: Our review of 1999 claims identified \$32 million in Medicare payments for claims with invalid unique identification numbers listed for the ordering physicians. Another \$59 million was paid for claims with inactive identification numbers. A small number of suppliers accounted for a substantial portion of these claims.

Savings (in Millions):

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
\$91	\$91	\$91	\$91	\$91

Status: CMS concurred with our recommendation and implemented an edit to reject claims listing a deceased physician's identification number. CMS decided not to implement edits for inactive and invalid physician identification numbers. Instead, the agency initiated provider education efforts and issued two program memorandums.

Report:

OEI-03-01-00110 (final report, 11/01)

Prevent Medicare Losses Resulting From Early Payments for Medical Equipment

Current Law: Medicare covers durable medical equipment (DME), prosthetics, orthotics, and supplies under Medicare Part B. Medicare allowed approximately \$6 billion for these claims in 1998.

Proposal (✓Regulatory): CMS should not pay for DME, prosthetics, orthotics, and supply claims before the service period has been completed.

Reason for Action: We found that Medicare could have earned an additional \$7.2 million in interest on 1998 payments for claims that were billed before the end of the service period. Four of seven insurers surveyed did not pay for services before the service period was completed.

Savings (in Millions):

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
\$7.2	\$7.2	\$7.2	\$7.2	\$7.2

Status: CMS did not concur with our recommendation and stated that delaying payment of DME, prosthetics, orthotics, and supply claims until the end of the service period would not be a desirable practice.

Report:

OEI-03-99-00620 (final report, 6/00)

Prevent Inappropriate Medicare Part B Payments for Medical Equipment in Skilled Nursing Facilities

Current Law: Federal law prohibits Medicare Part B durable medical equipment (DME) payments on behalf of beneficiaries who are in a skilled nursing facility in a qualifying Medicare Part A stay.

Proposal (✓*Procedural*): CMS should work with the DME regional carriers to implement edits to prevent inappropriate Medicare Part B DME payments for beneficiaries who are residents of skilled nursing facilities.

Reason for Action: Our review identified approximately \$35 million in inappropriate Medicare Part B payments for calendar years 1996 through 1998.

Savings (in Millions):

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
\$11.7	\$11.7	\$11.7	\$11.7	\$11.7

Status: CMS did not concur with our recommendation to install postpayment edits and stated that it would be impractical for the regional carriers to perform postpayment reviews to identify these situations. CMS has developed prepayment edits, which were expected to be implemented in April 2002. We are currently reviewing this issue to determine if the conditions have been corrected.

Report:

A-01-00-00509 (final report, 7/01)

Eliminate Semiannual Maintenance Payments for Capped Rental Equipment

Current Law: Medicare Part B covers certain durable medical equipment (DME) under the capped rental category. Beneficiary payments for capped rental equipment are made monthly and may not exceed 15 months of rental. After the rental period ends, Medicare contractors may request reasonable payments from Medicare beneficiaries for either continuing maintenance or repair of these items.

Proposal (✓*Legislative*): CMS should eliminate the semiannual maintenance payment allowed for capped rental equipment and pay for repairs only when needed. CMS also should consider whether eliminating the 15-month rental option is a viable solution. By requiring any continual rentals to be converted to a purchase after the 13th month of rental, the need for the semiannual maintenance payment would be automatically eliminated.

Reason for Action: Medicare’s current policy of paying for maintenance and servicing of capped rental equipment is not cost effective. Medicare pays substantially more in maintenance payments for rented items than it does for actual repairs on purchased equipment. Medicare beneficiaries are receiving little or no routine maintenance on their rented equipment.

Savings (in Millions):

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
\$98	\$98	\$98	\$98	\$98

Status: CMS concurred with our recommendation and has included in their FY 2005 budget a legislative proposal to eliminate the 15-month rental option for capped rental equipment by requiring that continuous rentals be converted to purchases after 13 months.

Report:

OEI-03-00-00410 (final report, 6/02)

Adjust Reimbursement for Semielectric Hospital Beds

Current Law: Section 1834 of Title XVIII of the Social Security Act contains special payment rules for six categories of durable medical equipment (DME).

Proposal (✓Regulatory): CMS should issue a final rule on the application of its inherent reasonableness authority so that this authority can be used to adjust the fee schedule amounts for procedure code E0260 pertaining to semielectric hospital beds.

Reason for Action: Our review disclosed that Medicare Part B fee schedule amounts for semielectric hospital beds remain high. Code E0260 fee schedule amounts were excessive when compared with combinations of other fee schedule amounts, such as code E0294 plus either E0305 or E0310 for a semielectric hospital bed with a mattress plus side rails. We estimated that using the alternative code combinations could save approximately \$34.3 million per year, consisting of \$25.9 million for monthly rental payments and \$8.4 million for maintenance and servicing fees.

Savings (in Millions):

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
\$34.3	\$34.3	\$34.3	\$34.3	\$34.3

Status: CMS concurred with OIG's recommendations but is waiting to initiate inherent reasonableness reviews until written procedures for conducting these reviews are developed. In accordance with the Medicare Prescription Drug, Improvement and Modernization Act of 2003, the Medicare fee schedule amounts for hospital beds will be reduced by the percentage difference between the 2002 Medicare fee schedule amounts and the median price paid under the Federal Employee Health Benefit plans in 2002. The percentage reduction takes effect in January 2005.

Report:

A-09-01-00109 (final report, 12/02)

Improve Billing Practices for Medicare Orthotics

Current Law: Medicare pays for prosthetics and orthotics, defined by regulation as leg, arm, back, and neck braces and artificial legs, arms, and eyes, including replacements if required because of a change in the beneficiary's physical condition. Orthotic devices, which are mainly covered under Medicare Part B, must be reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member.

Proposal (✓*Procedural*): CMS should improve Medicare billing for orthotics, including development of standards required for suppliers of custom molded/fabricated devices.

Reason for Action: Our recent review found continued inappropriate Medicare reimbursement for orthotics at significant levels. Thirty percent of beneficiaries had one or more miscoded devices. We also found that qualifications of orthotic suppliers varied; noncertified suppliers in our sample were the most likely to provide inappropriate devices.

Savings (in Millions):

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
\$43	\$43	\$43	\$43	\$43

Status: CMS generally concurred with our original recommendations. The agency is working on a proposed rule regarding orthotics and intends to put in place standards for custom orthotics.

Report:

OEI-02-95-00380 (final report, 10/97)

OEI-02-99-00120 (final report, 3/00)

OEI-02-99-00121 (final report, 3/00)

Improve Guidelines for Therapeutic Footwear

Current Law: The Medicare Part B benefit covers therapeutic footwear for beneficiaries with diabetes and one or more of six qualifying conditions. A doctor of medicine or a doctor of osteopathy who is treating the beneficiary's systemic diabetic condition under a comprehensive plan of care must certify the need for therapeutic footwear.

Proposal (✓*Procedural*): CMS should make Medicare coverage guidelines more explicit and improve documentation requirements for therapeutic footwear. CMS should also ensure that the therapeutic footwear benefit contains quality assurance safeguards.

Reason for Action: We found that documentation for 57 percent of therapeutic shoe claims included in our sample was missing or inadequate. We also found that because Medicare guidelines do not clearly define qualifications of nonphysician entities that furnish therapeutic footwear, quality assurance was problematic. Because less than 1 in 50 Medicare-aged diabetics received shoes in 1996, the potential for growth in the shoe program is enormous.

Savings (in Millions):

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
\$7	\$7	\$7	\$7	\$7

Status: CMS concurred with our recommendations and released a program memorandum in November 2001 requiring suppliers to indicate actual, accurate “start” and “end” dates on claim forms. CMS is working on a proposed rule to establish standards for suppliers of therapeutic shoes.

Report:

OEI-03-97-00300 (final report, 8/98)

Eliminate Inappropriate Billing for Blood Glucose Test Strips

Current Law: Medicare covers home blood glucose monitors and test strips for beneficiaries who must periodically test their blood sugar levels as part of their diabetes management, regardless of insulin usage.

Proposal (✓*Procedural*): CMS should (1) eliminate the inappropriate billings identified in our review by alerting suppliers to the importance of properly completing documentation to support claims for test strips and (2) require suppliers to indicate actual, accurate “start” and “end” dates on claim forms.

Reason for Action: We found that Medicare allowed \$79 million for blood glucose test strips based on claims with missing or flawed documentation.

Savings (in Millions):

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
\$79	\$79	\$79	\$79	\$79

Status: CMS concurred with our recommendations and released a program memorandum in November 2001 requiring providers to fill in start and end dates for glucose test strips.

Report:

OEI-03-98-00230 (final report, 6/00)

Examine Payment Method for Parenteral Nutrition

Current Law: Parenteral nutrition, a liquid solution provided intravenously through use of an indwelling catheter and infusion pump, is covered under Medicare’s Part B prosthetic device provision. Medicare uses the reasonable charge methodology to determine allowances for 23 parenteral nutrition procedure codes.

Proposal (✓*Legislative*, ✓*Procedural*): CMS should examine other payment methods that could lead to more cost-effective reimbursement for parenteral nutrition solutions. We suggest consideration of three alternative payment methods: inherent reasonableness, acquisition cost, and competitive bidding.

Reason for Action: For four parenteral nutrition codes, Medicare paid an average of 45 percent more than Medicaid agencies and 78 percent more than Medicare risk health maintenance organizations.

Savings (in Millions):

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
\$65	\$65	\$65	\$65	\$65

Status: CMS concurred with our recommendations and is considering options to determine the best approach to reduce and control costs for parenteral nutrition. CMS is also working on developing written procedures for conducting inherent reasonableness reviews. In accordance with the Medicare Prescription Drug, Improvement and Modernization Act of 2003, competitive acquisition of enteral nutrition durable medical equipment and off-the-shelf orthotics will be phased in beginning in 2007.

Report:

OEI-03-96-00230 (final report, 7/97)

Reduce and Control Enteral Nutrition Equipment Costs

Current Law: Enteral nutrition therapy, commonly called tube feeding, provides nourishment to patients who cannot swallow because of severe or permanent medical problems. This therapy, covered under Medicare Part B, is limited to patients unable to eat normally who require enteral therapy as their primary source of nutrition. Durable medical equipment (DME) regional carriers establish medical policy and guidelines for the review of DME claims.

Proposal (✓*Procedural*): DME regional carriers should consider selecting claims for special formulas, pump equipment, and/or pump supply kits when they determine target areas for focused medical reviews. Enteral nutrition therapy provided in nursing homes also should be covered under the nursing home daily rate.

Reason for Action: Eighty percent of the beneficiaries sampled met Medicare criteria for enteral nutrition therapy in 1995. However, we identified vulnerabilities in the use of special enteral formulas and the pump delivery method.

Savings (in Millions):

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
\$28	\$28	\$28	\$28	\$28

Status: CMS agreed with our recommendation. Medicare Part B coverage of enteral nutrition therapy continues to be provided for beneficiaries residing in a nursing facility when the stay is not covered by Medicare Part A.

Report:

OEI-03-94-00022 (final report, 6/97)

Reduce Medicare Part B Payments for Enteral Nutrition at Home

Current Law: Enteral nutrition therapy provides nourishment to patients who cannot swallow because of severe or permanent medical problems. This therapy, covered under Medicare Part B, is limited to patients who are unable to eat normally and require enteral therapy as their primary source of nutrition. While the majority of payments are for patients in nursing homes, some patients receive enteral therapy as part of home care.

Proposal (✓*Legislative*, ✓*Procedural*): CMS should reduce payments through competitive acquisition strategies for patients receiving enteral nutrition at home.

Reason for Action: Payments for enteral nutrition therapy are excessive because reimbursement rates are high and competitive acquisition strategies are not fully used. In our review of other payers of enteral nutrition, we found that payers who negotiated prices, taking advantage of discounts and other competitive acquisition strategies, reimbursed from 17 to 48 percent less than Medicare.

Savings (in Millions):

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
\$15	\$15	\$15	\$15	\$15

Status: CMS concurred that Medicare paid too much for enteral nutrients and supported the recommendation to reduce payments for enteral therapy administered at home. In accordance with the Medicare Prescription Drug, Improvement and Modernization Act of 2003, competitive acquisition of enteral nutrition will be phased in beginning in 2007.

Report:

OEI-03-94-00021 (final report, 4/96)

Improve Medical Reviews for Home Oxygen Therapy

Current Law: Medicare covers home oxygen therapy for beneficiaries diagnosed with significant hypoxemia (a deficiency in the amount of oxygen in the blood). A physician-signed certificate of medical necessity is required for payment. The Balanced Budget Act of 1997 mandated that the Secretary establish specific service standards for oxygen and oxygen equipment as soon as practicable. Home oxygen therapy accounts for the largest portion of Medicare durable medical equipment (DME) payments.

Proposal (✓Regulatory): CMS should target oxygen equipment claims for focused medical review and ensure that edits are in place at DME regional carriers to identify incomplete certificates of medical necessity. Further, CMS should establish specific service standards for home oxygen equipment as mandated by the Balanced Budget Act of 1997.

Reason for Action: Nearly one-quarter of oxygen certificates of medical necessity included in our study were inaccurate or incomplete. We estimate that the resultant cost to Medicare in 1996 was \$263 million. We also found that while all beneficiaries in our sample used their stationary oxygen equipment, 13 percent never used their portable systems, which resulted in a cost to Medicare of about \$9.7 million in 1996.

Savings (in Millions):

	<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
Certificates	\$263.0	\$263.0	\$263.0	\$263.0	\$263.0
Portable systems	9.7	9.7	9.7	9.7	9.7

Status: CMS concurred with our recommendations and formed a regulation team to develop proposed standards for suppliers of home oxygen equipment. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 authorized CMS to reduce reimbursement for oxygen and oxygen equipment in 2005.

Report:

OEI-03-96-00090 (final report, 8/99)

Stop Inappropriate Payments for Hyperbaric Oxygen Therapy

Current Law: Hyperbaric oxygen therapy (HBO2) was originally developed for the treatment of decompression sickness, but its primary use in the United States is for wound care. The CMS Coverage Instruction Manual, section 35-10, establishes 15 conditions for which hyperbaric therapy is reimbursable.

Proposal (✓Procedural): CMS should (1) initiate its national coverage decision process for HBO2, (2) strengthen policy guidance by clarifying existing language and incorporating new guidance on issues such as physician attendance and documentation, and (3) improve oversight of this therapy by requiring contractors to implement appropriate edits and medical review standards.

Reason for Action: Our inspection found substantial inappropriate payments in the \$49.9 million allowed for outpatient hospital and physician charges for HBO2 in 1997-98. Inappropriate payments were made for treatments that either were not in compliance with CMS guidelines or did not have sufficient documentation to support reimbursement, treatments deemed to be excessive, and treatments that lacked appropriate testing or monitoring. Inappropriate payments resulted from abuse of or confusion over the current coverage policy, treating physicians' medical opinions that did not align with CMS guidelines, inconsistent application of coverage criteria, inadequate documentation, and a failure by contractors to implement appropriate edits and medical review standards.

Savings (in Millions):

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
\$19.1	\$19.1	\$19.1	\$19.1	\$19.1

Status: CMS generally concurred with our recommendations. A national coverage decision for hyperbaric oxygen therapy, providing details on documentation and supervision requirements, was issued in April 2003. Additionally, CMS is currently addressing physician guidelines for hyperbaric oxygen and indicates that it intends to tighten its coverage policy and update its claims processing instructions accordingly. CMS indicated that it will also provide guidance to contractors on specific editing to further ensure appropriate payment.

Report:

OEI-06-99-00090 (final report, 10/00)

Reclassify Respiratory Assist Devices With a Back-Up Rate

Current Law: Medicare Part B covers durable medical equipment (DME) provided in a beneficiary’s residence when deemed medically necessary by a physician. This equipment includes respiratory assist devices with a back-up rate, a feature to detect when a patient has stopped or delayed breathing. The Omnibus Budget Reconciliation Act of 1993 amended the Social Security Act to exclude ventilators that are “either continuous airway pressure devices or intermittent assist devices with continuous airway pressure devices” from the “frequent and substantial servicing” payment category.

Proposal (✓Regulatory): CMS should reclassify bilevel respiratory assist devices with a back-up rate from the “frequent and substantial servicing” category to the “capped rental” category under the durable medical device benefit.

Reason for Action: The current Medicare payment for bilevel respiratory assist devices with a back-up rate is inappropriate because the equipment requires only routine maintenance and patient monitoring.

Savings (in Millions):

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
\$11.5	\$11.5	\$11.5	\$11.5	\$11.5

Status: CMS concurred with our recommendation and published a proposed rule in August 2003 clarifying that bilevel respiratory assist devices with back-up rate be paid as capped rental items.

Report:

OEI-07-99-00440 (final report, 6/01)

Medicare Managed Care

Modify Payments to Managed Care Organizations

Current Law: The Balanced Budget Act of 1997 established the Medicare+Choice program with the primary goal of providing a wider range of health plan choices to Medicare beneficiaries. The Act also modified the payment methodology under the program to correct excess payments, reduce geographic variations in payments, and align managed care organization (MCO) payments to reflect beneficiaries' health status.

Proposal (✓*Legislative*): CMS should modify monthly capitation rates to a level fully supported by empirical data.

Reason for Action: Based on numerous OIG reviews, studies by other agencies, and MCO data, we concluded that MCOs receive more than an adequate amount of funds to deliver the Medicare package of covered services. The basis used to calculate monthly capitation payments to MCOs was flawed, resulting in higher-than-necessary payments; Medicare payments funded excessive administrative costs; and MCOs did not account for investment income earned on Medicare funds.

Savings (in Millions):

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
\$3,500	\$3,500	\$3,500	\$3,500	\$3,500

Status: Although CMS initially agreed that Medicare+Choice payments were adequate to fund the Medicare package of covered services, the agency now believes that payments to MCOs, particularly those in minimum update counties, are not adequate. Agency officials stated that they would move toward full implementation of a risk adjustment methodology incorporating diagnosis data from physician services and hospital outpatient services. Subsequently, the Benefits Improvement and Protection Act of 2000 increased payments to MCOs. In addition, implementation of the risk adjustment methodology was extended over a longer period. Medicare Prescription Drug, Improvement and Modernization Act of 2003 increased payments to MCOs, including a provision to tie payments to Medicare outlays in fee-for-service sector. We will be updating our work to examine MCO payments as a result of all legislative changes.

Report:

A-14-00-00212 (final report, 9/00)

Monitor Managed Care Organizations' Rate Proposals

Current Law: To participate in the Medicare+Choice program, each managed care organization (MCO) must submit an adjusted community rate proposal to CMS before the contract period begins. The proposal is integral to pricing an MCO's benefit package, computing excess amounts (if any) in Medicare capitation payments, and determining additional and supplemental benefits or premiums that could be charged to Medicare enrollees.

Proposal (✓*Procedural*): CMS should monitor adjusted community rate proposals to ensure the accuracy of the data, work with MCOs to address the deficiencies noted in annual audits of the proposals, ensure that MCOs have accounting systems and procedures in place to properly prepare their proposals, and initiate the return of funds for plans that overcharged their enrollees.

Reason for Action: Our reviews of 186 rate proposals submitted by 55 MCOs found that:

- 49 percent were not prepared in accordance with CMS instructions
- 66 percent contained errors that affected at least one of the three components of an adjusted community rate
- 36 percent overstated the beneficiary premium/cost-sharing amounts, and/or the MCO should have offered additional benefits had the amounts for direct medical care, administration, average payment rate, and copayments been properly calculated

Savings (in Millions):

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
TBD	TBD	TBD	TBD	TBD

Status: CMS generally concurred with the recommendations. However, CMS had concerns with the methodology it thought we had used in calculating the impact on Medicare beneficiaries from overcharges and/or forfeited additional benefits. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 will replace the rate proposals with "plan bids" starting in 2006. If the monthly Medicare payment amount exceeds the monthly bid amount, 75 percent of the resultant savings will be given to the beneficiary in the form of additional benefits and/or reduced premiums with the remaining 25 percent retained by the Federal Government. Thus, the accuracy of the underlying cost assumptions in the bid proposals will affect Federal funds.

Report:

A-09-01-00051 (final report, 7/02)

Place a Ceiling on Administrative Costs Included in Managed Care Organizations' Rate Proposals

Current Law: Each risk-based managed care organization (MCO) is required to submit an adjusted community rate proposal to CMS before the beginning of the contract period. Administrative costs, which are one component of the proposal, include costs associated with facilities, marketing, taxes, depreciation, reinsurance, interest, and other nonmedical compensation. CMS does not require a reasonable percentage or ceiling on the administrative cost rate proposed as it does in other areas of the Medicare program.

Proposal (✓*Legislative*, ✓*Procedural*): CMS should institute a reasonable ceiling on the administrative costs permitted in an MCO proposal. We suggest an administrative rate ceiling of 15 percent of total revenue requirements, which was MCOs' average rate during our review period (1996 to 1999).

Reason for Action: As a percentage of the total rate proposed, the administrative rate varied widely among MCOs reviewed, regardless of the type of MCO (individual practice association, group, or staff) or the tax status (profit or nonprofit). For the 1999 rate proposals, the amount allocated for administrative purposes ranged from a high of 32 percent to a low of 3 percent. Using 1998 data, if a 15-percent ceiling had been applied to the MCOs we reviewed, an additional \$1 billion could have been passed on to the beneficiaries in the form of additional benefits or reduced payments (e.g., deductibles and/or coinsurance).

Savings (in Millions):

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
TBD	TBD	TBD	TBD	TBD

Status: Although CMS agreed that it should more thoroughly analyze rate proposals, it did not agree with our recommendation to institute a ceiling on the administrative costs included in an MCO rate proposal. During our review period, administrative costs included amounts for additional revenues (i.e., profits). Effective contract year 2000, administrative costs exclude amounts for additional revenues. Therefore, the 15-percent ceiling would be more than reasonable.

Under provisions of the Medicare Prescription Drug, Improvement and Modernization Act of 2003, the proposals will be replaced by “plan bids” starting in the year 2006. The legislation gives the Secretary authority to negotiate the monthly bid amount similar to the Federal Employee Health Benefit program. This program limits administrative costs to a negotiated amount and employs the Federal Acquisition Regulations in determining allowable/reasonable costs—the same criteria used in our review.

Report:

A-14-98-00210 (final report, 1/00)

Pay Managed Care Organizations Only Reasonable Administrative Costs

Current Law: Following a CMS-prescribed methodology, each risk-based managed care organization (MCO) is required to submit an adjusted community rate proposal before the beginning of the contract period. Through this process, MCOs present to CMS their estimate of the funds needed to provide the Medicare package of covered services to enrolled beneficiaries. The estimated funds are calculated to cover the plan’s medical and administrative costs for the upcoming year. Administrative costs include marketing, taxes, depreciation, reinsurance, interest, and other nonmedical compensation.

Proposal (✓Legislative, ✓Procedural): CMS should pursue legislation to require risk-based MCOs, when estimating administrative costs, to follow Medicare’s general principle of paying only reasonable costs. CMS should also publish the administrative cost rates of all MCOs participating in the Medicare program.

Reason for Action: Our review of the administrative costs included in the 1997 proposals submitted by nine MCOs found that \$66.3 million of the actual administrative costs incurred would have been recommended for disallowance had the MCOs been required to follow Medicare’s general principle of paying only reasonable costs. Since no statutory or regulatory authority governs allowability of costs included in the rate proposal, the MCOs were not required to adhere to this principle.

Conducted at CMS’s request, our subsequent review included 10 MCOs’ adjusted community rate proposals for 2000. We found that \$97.1 million in base-year administrative costs would have been recommended for disallowance had the MCOs been required to follow Medicare’s general principle of paying only reasonable costs.

Savings (in Millions):

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
TBD	TBD	TBD	TBD	TBD

Status: CMS did not agree with our recommendations. Agency officials stated that the revised rate proposals require MCOs to report administrative costs actually incurred for Medicare plans. However, we believe that the revised proposals do not address the reasonableness of costs. Under provisions of the Medicare Prescription Drug, Improvement and Modernization Act of 2003, the proposals will be replaced by “plan bids” starting in the year 2006. The legislation gives the Secretary authority to negotiate the monthly bid amount similar to the Federal Employee Health Benefit program. This program limits administrative costs to a negotiated amount and employs the Federal Acquisition Regulations in determining allowable/reasonable costs—the same criteria used in our review.

Report:

A-03-98-00046 (final report, 1/00)

Monitor Investment Income Earned by Risk-Based Managed Care Organizations

Current Law: Under the Medicare+Choice program, Medicare pays predetermined per capita payments to managed care organizations (MCOs) by the first of every month. In exchange for these capitation payments, MCOs are required to provide all Medicare-covered services to their members.

Proposal (✓Legislative): CMS should pursue legislation to either (1) adjust the timing of Medicare prepayments to MCOs to maximize the Health Insurance Trust Fund's earnings while minimizing MCOs' opportunities to earn investment income on Medicare funds or (2) adjust MCO payment rates to recognize the impact of investment income on the total funding available to MCOs for servicing their Medicare enrollees. Until such legislation is enacted, CMS should develop policies on tracking, estimating, and reporting investment income to ensure that investment income funds are used for program purposes and for the benefit of Medicare enrollees.

Reason for Action: Presently, MCOs with risk contracts are not required to account for investment income, which is earned from the time MCOs receive payment from CMS until these funds are disbursed to providers. We found that MCOs earned in excess of \$100 million a year on current-year Medicare funding during 1996 and 1997 and continued to earn significant amounts of investment income in 1998. On average, plans earned an estimated 5-percent return from short-term investments of Medicare prepayment funding. As a result, we are concerned that MCOs were effectively funded at a greater amount (approximately 0.4 percent more) than the 95 percent of Medicare fee-for-service costs used as a basis for calculating MCO payment rates.

Savings (in Millions):

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
\$150	\$150	\$150	\$150	\$150

Status: CMS agreed that its policies should hold MCOs accountable for investment income earned on current Medicare funds and should ensure that such income is used to benefit Medicare enrollees. However, CMS did not intend to pursue immediate legislative changes.

Under the Medicare Prescription Drug, Improvement and Modernization Act of 2003, the MCOs will negotiate their Medicare contracts using "plan bids" starting in the year 2006. The legislation gives the Secretary authority to negotiate the monthly bid amount similar to the Federal Employee Health Benefit program. Interest earned by plans participating in the program is considered when setting the annual rates.

Report:

A-02-98-01005 (final report, 8/00)

Other Medicare Reimbursement

Change the Way Medicare Pays for Clinical Laboratory Tests

Current Law: Medicare pays for most clinical laboratory tests based on fee schedules. These schedules, effective July 1, 1984, generally were established by each carrier at 60 percent of the Medicare prevailing charge (the charge most frequently used by all suppliers). The Balanced Budget Act of 1997 reduced fee schedule payments by lowering the cap to 74 percent of the median for payment amounts beginning in 1998, but the Benefits Improvement and Protection Act of 2000 raised the fee schedule amounts to 100 percent of the median for “new tests” performed on or after January 1, 2001. Also, no inflation update was permitted between 1998 and 2002. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 mandated that the annual adjustment to the clinical laboratory fee schedule for 2004 through 2008 shall be 0 percent.

Proposal (✓Legislative, ✓Procedural): We have continually recommended that CMS (1) review payment levels for laboratory services and (2) reinstate the beneficiary coinsurance and deductible provisions for laboratory services as a means of controlling utilization.

Reason for Action: Although prices on individual tests are being reduced by legislation, we continue to believe that payments for laboratory services need to be evaluated. In addition, our previous work indicated that these conditions have contributed to the significant increase in the use of laboratory services. And, because of the potential for overutilization and the fact that beneficiaries are not always aware of the tests being performed, we believe that CMS should reconsider our recommendation to study the reinstatement of beneficiary coinsurance and deductible provisions for laboratory services.

Savings (in Millions):

	<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
Panel	TBD	TBD	TBD	TBD	TBD
Copayment	\$1,130	\$1,240	\$1,370	\$1,960	\$2,130

Status: CMS has taken corrective actions to reduce payments for laboratory services. A proposal to reduce payment updates from 2003 through 2005 was included in the President’s FY 2001 budget, as well as a proposal to reinstate laboratory cost sharing. Neither of these proposals was enacted. In addition, the Balanced Budget Act of 1997 required the Secretary to request that the Institute of Medicine conduct a study of Part B laboratory test payments. CMS may use the results to develop new payment methodologies. CMS now requires that automated multi-channel tests be billed individually and are bundled by the FI and carrier to determine payment amounts.

Report:

A-09-89-00031 (final report, 1/90)

A-09-93-00056 (follow-up report, 1/96)

Adjust Home Health Agency Prospective Payments

Current Law: The Balanced Budget Act of 1997, as amended, required CMS to develop a prospective payment system for home health agencies. This system was implemented on October 1, 2000.

Proposal (✓*Legislative*): CMS should adjust for the costs of unnecessary services and other improper payments and eliminate them from the prospective payment system rates for home health agencies.

Reason for Action: In developing the prospective payment system rates, CMS used cost reports to develop base rates. However, CMS did not make a downward adjustment for substantial unallowable costs claimed by home health agencies, which we identified in prior audits. As a result, we are concerned that the rates are inflated and that home health agencies will be overpaid.

Savings (in Millions):

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
TBD	TBD	TBD	TBD	TBD

Status: While recognizing that the issue merits further review, CMS disagreed with our recommendation because it believes that actions have already been taken to ensure accurate and fair payments. The CMS believes that several factors nullify any need for further payment rate changes, including the payment reduction, effective FY 2003, imposed by the Congress.

Report:

A-04-99-01194 (final report, 11/99)

Require Physician Examination Before Ordering Home Health Services

Current Law: Section 1861 of Title XVIII of the Social Security Act authorized Medicare Part A payments for home health services. Home health services are a covered Medicare service. Prior to the implementation of the prospective payment system for home health services on October 1, 2000, providers were paid on a cost basis subject to limits established by the Department. Home health agencies are now reimbursed under a prospective payment system.

Proposal (✓Regulatory): CMS should revise Medicare regulations to require that physicians examine patients before ordering home health care. As discussed under “Status,” other recommendations to correct abusive and wasteful practices are being addressed.

Reason for Action: Audits and investigations have identified medically unnecessary care and inappropriate or fraudulent billing by specific home health agencies. Other OIG studies describe extreme variations and broad patterns of billing by these agencies, which raise questions about the appropriateness of some billings. We therefore believe that it is necessary to place systematic controls on the home health benefit to prevent abuse.

Savings (in Millions):

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
TBD	TBD	TBD	TBD	TBD

Status: Although the Balanced Budget Act of 1997 included provisions to restructure home health benefits, CMS still needs to revise regulations to require that physicians examine Medicare patients before ordering home health services. After the law’s enactment, our four-State review found that unallowable services continued to be provided because of inadequate physician involvement. While agreeing in principle, CMS said that it would continue to examine both coverage rules and conditions of participation to develop the discipline necessary for ensuring proper certification. CMS also provided additional payments for physician care plan oversight and education for physicians and beneficiaries.

Report:

A-04-94-02078 (final report, 2/95)	A-04-97-01169 (final report, 4/99)
A-04-94-02087 (final report, 6/95)	A-04-97-01170 (final report, 4/99)
A-04-95-01103 (final report, 3/96)	A-02-97-01034 (final report, 9/99)
A-04-95-01106 (final report, 3/96)	A-04-98-01184 (final report, 9/99)
A-04-95-01104 (final report, 6/96)	A-04-99-01194 (final report, 11/99)
A-04-95-01105 (final report, 9/96)	A-04-99-01195 (final report, 3/01)
A-04-95-01107 (final report, 9/96)	OEI-12-94-00180 (final report, 5/95)
A-03-95-00011 (final report, 11/96)	OEI-02-94-00170 (final report, 6/95)
A-04-96-02121 (final report, 7/97)	OEI-04-93-00260 (final report, 7/95)
A-02-97-01026 (final report, 9/97)	OEI-04-93-00262 (final report, 9/95)
A-04-97-01166 (final report, 4/99)	

Adjust Base-Year Costs in the Prospective Payment System for Skilled Nursing Facilities

Current Law: The Balanced Budget Act of 1997 required CMS to develop a prospective payment system for skilled nursing facilities effective for cost reporting periods beginning July 1, 1998.

Proposal (✓*Legislative*): CMS should determine the costs of unnecessary services and other improper payments and eliminate them from the prospective payment system rates for skilled nursing facilities.

Reason for Action: To develop the prospective payment system rates, CMS used cost reports for reporting periods beginning in FY 1995. However, CMS did not make a downward adjustment for substantial unallowable costs claimed by nursing facilities, which we identified in prior audits. As a result, we are concerned that the rates are inflated and that nursing facilities will be overpaid. Also, we found that improper Medicare payments for physical and occupational therapy in skilled nursing facilities totaled more than \$1 billion in 1998. The cost of unnecessary and undocumented therapy, as well as the markup on occupational therapy, was not identified before implementation of the prospective payment system.

Savings (in Millions):

	<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
Physical and occupational therapy	\$1,000+	\$1,000+	\$1,000+	\$1,000+	\$1,000+
All other	TBD	TBD	TBD	TBD	TBD

Status: CMS initially agreed with our recommendation but no additional analysis has been done.

Report:

A-14-98-00350 (final report, 7/98)

A-06-99-00058 (final report, 12/99)

OEI-09-97-00122 (final report, 11/00)

Eliminate Overpayments Under Consolidated Billing by Skilled Nursing Facilities

Current Law: The Balanced Budget Act of 1997 required implementation of a prospective payment system for skilled nursing facilities, as well as consolidated billing by these facilities. Under the prospective payment system, a skilled nursing facility is reimbursed a prospective payment for all covered skilled nursing services rendered to its residents in a Part A stay, and outside providers and suppliers must bill the facility for services rendered. Under consolidated billing, the facility is responsible for billing all covered skilled nursing services, including services provided under arrangement with outside parties.

Proposal (✓*Procedural*): CMS should establish payment edits in its Common Working File and Medicare contractors' claim processing systems to ensure compliance with consolidated billing requirements.

Reason for Action: For over one-third of the claims examined in our pilot review, we found that Medicare contractors made separate Part B payments to outside suppliers for services that were subject to consolidated billing. These services were included in the prospective payments that Medicare made to the skilled nursing facilities. As a result, the Medicare program paid twice for the same service—once to the nursing facility under the Part A prospective payment and again to the outside supplier under Part B. Our subsequent nationwide review identified \$47.6 million in potentially improper Medicare payments during calendar year 1999 for services that were subject to consolidated billing.

Savings (in Millions):

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
\$47.6	\$47.6	\$47.6	\$47.6	\$47.6

Status: CMS concurred with our recommendation and implemented edits in 2002. We are continuing our work to test the effectiveness of the edits and to identify any additional overpayments. We currently are reviewing this area to determine if substantial errors are still present.

Report:

A-01-99-00531 (final report, 3/00)

A-01-00-00538 (final report, 6/01)

Ensure Appropriateness of Medicare Payments for Mental Health Services

Current Law: Section 1862(a)(1)(A) of the Social Security Act requires all services, including mental health, to be reasonable and necessary for the diagnosis or treatment of an illness or injury.

Proposal (✓Procedural): CMS should ensure that mental health services are medically necessary, reasonable, accurately billed, and ordered by an authorized practitioner by using a comprehensive program of targeted medical reviews, provider education, improved documentation requirements, and increased surveillance.

Reason for Action: Claim error rates have exceeded 34 percent, suggesting widespread problems across a variety of provider types and care settings. Billing abuses involving beneficiaries who are unable to benefit from psychotherapy demonstrate a special need for enhanced program and beneficiary protections. Also, beneficiaries with mental illness sometimes do not receive all the services that they need, so that both underutilization and overutilization problems exist.

“Partial hospitalization” services, which may be provided by both hospitals and community mental health centers, have been particularly troublesome. These intensive services are designed to reduce the need for hospitalization of beneficiaries with serious mental illness. Payment error rates for partial hospitalization in community mental health centers have been estimated as high as 92 percent. A number of these centers were terminated from the program after CMS determined that they did not meet certification requirements. Reviews of outpatient psychiatric services provided by both acute care and specialty psychiatric hospitals also revealed high payment error rates, particularly relating to partial hospitalization services.

Savings (in Millions):*

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
\$676	\$676	\$676	\$676	\$676

**Includes \$224 million for acute hospital outpatient services, \$180 million for partial hospitalization in community mental health centers, \$57 million for psychiatric hospital outpatient services, \$30 million for nursing home services, and \$185 million for other mental health services.*

Status: Concurring with the individual reports, CMS has initiated some efforts, particularly regarding community mental health centers. We currently are reviewing this area to determine if substantial errors are still present.

Report:

A-04-98-02145 (final report, 10/98)
A-01-99-00507 (final report, 3/00)
A-01-99-00530 (final report, 12/00)

OEI-02-99-00140 (final report, 1/01)
OEI-03-99-00130 (final report, 5/01)

Conduct Medical Reviews of Part B Therapy Services

Current Law: Medicare coverage guidelines state that therapy must be reasonable, necessary, specific, and an effective treatment for the patient's condition.

Proposal (✓*Procedural*): CMS should instruct fiscal intermediaries to conduct focused medical reviews of therapy payments and encourage them to educate providers about documentation requirements. Additionally, CMS should consider options when developing a new reimbursement system for Part B therapy, such as a system based on an episode of therapy and prior authorization for therapy that exceeds a separate monetary cap for each type of therapy.

Reason for Action: We found that 14 percent of sampled physical, occupational, and speech therapy services in 1999 were not medically necessary and that approximately 10 percent were not adequately supported by documentation. We estimated that Medicare allowed \$97 million for unnecessary, undocumented, and inadequately documented therapy.

Savings (in Millions):

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
\$97	\$97	\$97	\$97	\$97

Status: CMS instructed its contractors to concentrate their efforts on random reviews of all claims and planned to use the results of those reviews to focus additional efforts. The Balanced Budget Refinement Act of 1999 required the Secretary to conduct focused medical reviews of therapy services during 2000 and 2001. Using Medicare Integrity Program funds, CMS awarded a contract for the Therapy Review Program, a study of the utilization of therapy services in 1998, 1999, and 2000. It will perform a significant number of focused medical reviews of therapy claims in skilled nursing facilities and other therapy settings.

Report:

OEI-09-97-00122 (final report, 8/99)
OEI-09-99-00550 (final report, 11/00)
OEI-09-99-00560 (final report, 8/01)

Ensure the Medical Necessity of Ambulance Claims

Current Law: CMS regulations state that Medicare covers ambulance services only if other forms of transportation are contraindicated by the beneficiary's condition. The Balanced Budget Act of 1997 mandated that CMS work with the industry to establish a negotiated fee schedule for ambulance payments effective January 1, 2000.

Proposal (✓Procedural): CMS should develop a prepayment edit to verify the medical necessity of ambulance claims that are not associated with hospital or nursing home admissions or emergency room care. This proposal would provide a solution for one group of ambulance services until CMS and the industry can better address issues of medical necessity, including clear and consistent definitions.

Reason for Action: Two-thirds of ambulance services that did not result in hospital or nursing home admissions or emergency room care on the same date were medically unnecessary. We estimate that Medicare allows approximately \$104 million each year for these medically unnecessary services.

Savings (in Millions):*

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
\$104	\$104	\$104	\$104	\$104

**Savings may depend on the timing and nature of the fee schedule mandated by the Balanced Budget Act.*

Status: The Medicare Prescription Drug, Improvement and Modernization Act of 2003 made several changes in payment for ambulance services. CMS is currently updating its work to examine medical necessity of both emergency and nonemergency transports.

Report:

OEI-09-95-00412 (final report, 12/98)

Stop Inappropriate Payments for Chiropractic Maintenance Treatments

Current Law: In 1972, section 273 of the Social Security Amendments (P.L. 92-603) expanded the definition of “physician” under Medicare Part B to include chiropractors. Currently, the only Medicare reimbursable chiropractic treatment is manual manipulation of the spine to correct a subluxation. Effective January 1, 2000, the Balanced Budget Act of 1997 eliminated the requirement for an x ray to demonstrate subluxation of the spine; a subluxation may now be demonstrated by an x ray or by physical examination. The Act also required the development of utilization guidelines for chiropractic services and treatment.

Proposal (✓*Procedural*): CMS should develop system edits to detect and prevent unauthorized payments for chiropractic maintenance treatments. Examples include (1) requiring chiropractic physicians to use modifiers to distinguish the categories of spinal joint problems and (2) requiring all Medicare contractors to implement system utilization frequency edits to identify beneficiaries receiving consecutive months of minimal therapy.

Reason for Action: We found that Medicare, Medicaid, and private insurers rely, in varying degrees, on utilization caps, x rays, physician referrals, copayments, and prepayment and postpayment reviews to control utilization of chiropractic benefits. Copayments are the most widely used utilization controls, but these and other controls did not detect or prevent unauthorized Medicare maintenance treatments. We concluded that 759,400 Medicare beneficiaries received 2.9 million probable chiropractic maintenance treatments at a cost to the Medicare program of almost \$69 million in 1996.

Savings (in Millions):

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
\$186	\$186	\$186	\$186	\$186

Status: CMS plans to move forward with its efforts to require that all contractors establish systems utilization frequency edits and that chiropractic physicians use modifiers distinguishing the categories of spinal joint problems. In the interim, in some instances, contractors are reviewing chiropractic claims on a postpayment basis and are detecting maintenance therapy through data analysis.

Report:

OEI-06-97-00480 (final report, 9/98)

OEI-04-97-00490 (final report, 11/98)

Recover Overpayments and Prevent Inappropriate Medicare Part B Payments for Nail Debridement and Related Services

Current Law: Podiatry services, including nail debridement, performed within the scope of applicable State licenses are generally reimbursable under the Medicare program.

Proposal (✓Procedural): CMS should (1) require Medicare carriers to recoup the overpayments found in our sample and to carefully scrutinize payments for nail debridement services through medical reviews, (2) require podiatrists to adequately document the medical necessity of all nail debridement services, and (3) require the CMS regional offices and carriers to educate podiatrists on Medicare payment policies for nail debridement claims.

Reason for Action: Based on our medical review of calendar year 2000 claims, we estimated that \$51.2 million was inappropriately paid for nail debridement services. Over half of these nail debridement claims contained related podiatry services. When a nail debridement service is determined to be inappropriate, all podiatry payments for related services are also inappropriate. Medicare paid \$45.6 million for such related services.

Savings (in Millions):

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
\$96.8	\$96.8	\$96.8	\$96.8	\$96.8

Status: CMS concurred with our recommendations. The agency planned to continue to maximize the effectiveness of its medical review strategy and collect the overpayments identified in our sample. CMS prepared a provider education article in order to educate podiatrists on Medicare policy for paying nail debridement claims.

Report:

OEI-04-99-00460 (final report, 6/02)

Expand Medicare Secondary Payer Provisions for End Stage Renal Disease Benefits

Current Law: The Omnibus Budget Reconciliation Act of 1981 changed the status of Medicare from primary to secondary payer for beneficiaries with end stage renal disease (ESRD) for the first 12 months of Medicare eligibility or entitlement. Effective November 5, 1990, Medicare became secondary payer for the first 18 months of Medicare entitlement. The Balanced Budget Act of 1997 made Medicare the secondary payer for the first 30 months of Medicare eligibility.

Proposal (✓*Legislative*): CMS should pursue legislation to extend the Medicare secondary payer provision to include ESRD beneficiaries without a time limitation.

Reason for Action: The proposed change for ESRD beneficiaries would make Medicare secondary payer provisions consistent with legislation passed by the Congress for aged and disabled beneficiaries, which does not restrict the period that Medicare is the secondary payer.

Savings (in Millions):

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
TBD	TBD	TBD	TBD	TBD

Status: CMS was concerned that an indefinite secondary payer provision might encourage insurers to drop uneconomical services, namely facility dialysis and transplantation. We continue to advocate that when Medicare eligibility is due solely to ESRD, the group health plan should remain primary until the beneficiary becomes entitled to Medicare based on age or disability and is not currently employed. At that point, Medicare would become the primary payer.

Report:

A-10-86-62016 (final report, 12/87)

Medicaid Reimbursement

Eliminate or Reduce Transition Periods for Compliance With New Medicaid Upper Payment Limits

Current Law: In a final rule published in January 2001, CMS revised the Medicaid upper payment limit regulations to provide for three separate aggregate upper limits—one each for private, State, and non-State government-owned facilities. The rule included 5- and 8-year transition periods for States with approved rate enhancement State plan amendments. The applicable transition period depended on the effective date of these amendments.

Proposal (✓*Legislative*, ✓*Regulatory*, ✓*Procedural*): CMS should seek authority to eliminate or reduce the 5- and 8-year transition periods included in the new upper payment limit regulations.

Reason for Action: We believe that the transition periods included in the regulations are longer than needed for States to adjust their financial operations in response to the new upper payment limits.

Savings (in Millions):

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
TBD	TBD	TBD	TBD	TBD

Status: CMS did not concur with our recommendation. According to CMS, the transition periods were established pursuant to either notice-and-comment rulemaking or legislation, and offering new proposals at this time would undermine the consensus reached through those processes. CMS anticipates no further action on our recommendation.

Report:

A-03-00-00216 (final report, 9/01)

Delay or Repeal the Increase in Medicaid Disproportionate Share Hospital Payments

Current Law: The Benefits Improvement and Protection Act of 2000 modified the disproportionate share hospital (DSH) payment limit applicable to public hospitals in all States. Beginning on the first day of the State FY that begins after September 30, 2002, and continuing for 2 years, the DSH limit will increase from 100 percent to 175 percent of uncompensated care costs.

Proposal (✓*Legislative*, ✓*Procedural*): CMS should consider seeking legislative reform to ensure that DSH funds remain at the hospitals to provide care to vulnerable populations, rather than being returned to the States through intergovernmental transfers. OIG also believes that any Medicaid payment returned by a provider to the State should be treated as a credit applicable to the Medicaid program. CMS should also perform any other studies of the DSH program that it deems appropriate to evaluate the reasonableness of DSH reimbursement.

Reason for Action: Based on audits in four States, we believe that DSH payments are not always retained and used by public hospitals and that the DSH funds received are not always calculated correctly. We are concerned that by raising the limit to 175 percent, additional DSH funds may not actually be retained by public hospitals or the amount of incorrect DSH payments may increase. Even after the increase to 175 percent ends after State FY 2004, problems with DSH funds not remaining at the providers will continue.

Savings (in Millions):

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
TBD	TBD	-	-	-

Status: CMS initially concurred with our recommendations. However, when commenting on the final report, CMS stated that the President's FY 2003 budget did not seek a change in DSH legislation. The President's FY 2004 and FY 2005 budgets also did not seek a change in DSH legislation.

Report:

A-06-01-00069 (final report, 12/01)

Require That Medicaid Reimbursement for Brand Name Drugs Be More in Line With Acquisition Costs

Current Law: Most States use average wholesale price (AWP) minus a percentage discount, which varies by State, as a basis for reimbursing pharmacies for drug prescriptions.

Proposal (✓*Legislative*, ✓*Procedural*): CMS should encourage the States to bring pharmacy reimbursement more in line with the actual acquisition cost of brand name drugs being realized by pharmacies in their States. We recommended a four-tier approach to reimbursement as follows: single-source innovator drugs, all drugs without Federal upper payment limits, multiple-source drugs without Federal upper payment limits, and multiple-source drugs with Federal upper limits.

Reason for Action: The discount below AWP averaged 10.31 percent nationally in 1999. We believe that this is not a sufficient discount to ensure that a reasonable price is paid for drugs. Our review, based on calendar year 1999 data, estimated that the actual acquisition cost for brand name drugs was an average of 21.84 percent below AWP, an increase of 19.3 percent over our previous estimate based on calendar year 1994 data.

Savings (in Millions):

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
\$1,080	\$1,080	\$1,080	\$1,080	\$1,080

Status: CMS concurred with our recommendation and is working with States to review their estimates of acquisition costs in light of our findings. However, legislation may be needed to implement the four-tiered approach that we have recommended, which could bring about substantial savings nationwide. We will continue to monitor the pricing of Medicaid drug reimbursements for brand name drugs.

Report:

A-06-00-00023 (final report, 8/01)

A-06-02-00041 (final report, 9/02)

Require That Medicaid Reimbursement for Generic Drugs Be More in Line With Acquisition Costs

Current Law: Most States use average wholesale price (AWP) minus a percentage discount, which varies by State, as a basis for reimbursing pharmacies for drug prescriptions.

Proposal (✓*Legislative*, ✓*Procedural*): CMS should encourage the States to bring pharmacy reimbursement more in line with the actual acquisition cost of generic drugs being realized by pharmacies in their States. We recommended a four-tier approach to reimbursement as follows: single-source innovator drugs, all drugs without Federal upper payment limits, multiple-source drugs without Federal upper payment limits, and multiple-source drugs with Federal upper limits.

Reason for Action: The discount below AWP averaged 10.31 percent nationally in 1999. We believe that this is not a sufficient discount to ensure that a reasonable price is paid for drugs. Our review, based on calendar year 1999 data, estimated that the actual acquisition cost for generic drugs was an average of 65.93 percent below AWP, an increase of over 55 percent from our previous estimate based on calendar year 1994 data.

Savings (in Millions):

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
\$470	\$470	\$470	\$470	\$470

Status: CMS concurred with our recommendation. The agency is working with States to strongly encourage them to review their estimates of acquisition costs and will follow up to ensure that they take our findings into account. However, legislation may be needed to implement the four-tiered approach that we have recommended, which could bring about substantial savings nationwide. We will continue to monitor the pricing of Medicaid drug reimbursements for generic drugs.

Report:

A-06-01-00053 (final report, 3/02)

A-06-02-00041 (final report, 9/02)

Review Medicaid Reimbursement Methodology for HIV/AIDS Drugs

Current Law: Title XIX of the Social Security Act established Medicaid as a jointly funded, Federal-State health insurance program to provide medical services to low-income persons. Medicaid, the largest source of public coverage for prescription drugs, provides prescription drug benefits for almost half of the 335,000 persons living with HIV/AIDS who receive regular care. In FY 1999, Medicaid spent \$617 million for antiretroviral drugs to treat HIV/AIDS.

Proposal (✓Procedural): CMS should review the current reimbursement methodology and work with States to more accurately estimate pharmacy acquisition costs for 16 HIV/AIDS antiretroviral drugs examined in our report and initiate a review of Medicaid rebates for them.

Reason for Action: Medicaid pays up to 33 percent more than other Federal Government drug discount programs for 16 HIV/AIDS antiretroviral drugs. Medicaid could have saved \$102 million in Federal/State funds (\$54 million Federal share) in FY 2000 if the 10 States we surveyed had purchased these antiretrovirals at the Federal ceiling price used by the Department of Veterans Affairs, the Department of Defense, the Coast Guard, and certain public health agencies. The program could have saved \$140 million (\$73 million Federal share) if all States' payments for HIV/AIDS antiretroviral drugs had been limited by these Federal ceiling prices.

Savings (in Millions):

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
\$144	\$148	\$152	\$156	\$160

Status: Some unknown portion of the costs for these drugs will be addressed by the implementation of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 for those beneficiaries who are dually eligible for Medicare and Medicaid. It is unclear at this time what action CMS may take in regards to the cost of these drugs.

Report:

OEI-05-99-00611 (final report, 7/01)

Establish Connection Between the Calculation of Medicaid Drug Rebates and Drug Reimbursement

Current Law: The Omnibus Budget Reconciliation Act of 1990 authorized States to collect rebates from drug manufacturers for drug purchases made under the Medicaid program. Rebates are calculated using average manufacturer price (AMP), the manufacturer's best price, and other factors. In contrast, most States reimburse pharmacies for Medicaid prescription drugs based on the average wholesale price (AWP) of the drug.

Proposal (✓*Legislative*, ✓*Procedural*): CMS should seek legislation that would require drug manufacturers participating in the Medicaid outpatient prescription drug program to pay Medicaid drug rebates using the same basis as reimbursements made to pharmacies or study other viable alternatives to the current program of using AMP to calculate rebates.

Reason for Action: Requiring manufacturers to pay Medicaid drug rebates using the same basis as reimbursements made to pharmacies would (1) eliminate inconsistencies in the present methods used by drug manufacturers to calculate AMP; (2) establish a much-needed connection between the calculation of Medicaid drug rebates and the calculation of Medicaid reimbursement for drugs at the pharmacy level; and (3) reduce the burden of administering the Medicaid drug rebate program at the Federal, State, and manufacturer levels.

Savings (in Millions):*

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
TBD	TBD	TBD	TBD	TBD

**The legislative change would have resulted in about \$1.15 billion in added rebates for 100 brand name drugs that had the greatest amount of Medicaid reimbursement in 1994-96.*

Status: CMS agreed to pursue a change in the Medicaid drug rebate program similar to that recommended. However, no changes have yet been made.

Report:

A-06-97-00052 (final report, 5/98)

Implement an Indexed Best Price Calculation in the Medicaid Drug Rebate Program

Current Law: The Omnibus Budget Reconciliation Act of 1990 authorized States to collect rebates from drug manufacturers for drug purchases made under the Medicaid program. Rebates are calculated using average manufacturer price (AMP), the manufacturer’s best price, and other factors. To discourage drug manufacturers from raising AMP amounts, the basic rebate amount is increased by the amount that AMP increases over and above the consumer price index for all urban consumers. However, no similar indexing of best price is made, even though best price is part of the basic rebate calculation for brand name drugs.

Proposal (✓*Legislative*): CMS should pursue legislation to index the best price calculation in the Medicaid drug rebate program to the consumer price index-urban.

Reason for Action: Since the inception of the Medicaid drug rebate program, drug manufacturers have consistently increased best prices in excess of the consumer price index for all urban consumers. To determine the potential effect that increases in best price (beyond the rate of inflation) had on rebates, we calculated the difference in rebates that would have resulted from using an indexed best price. We estimate that drug rebates would have increased by about \$123 million for the 406 drugs included in our review.

Savings (in Millions):

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
\$123	\$123	\$123	\$123	\$123

Status: CMS continues to disagree with the recommendation. We are continuing to monitor the drug rebate program; audits will continue to focus on enhancing the collection of rebates and providing potential savings to the rebate program.

Report:

A-06-94-00039 (final report, 10/95)

Review Cost Effectiveness of “Pay and Chase” Methods for Medicaid Pharmacy Third-Party Liability Recoveries

Current Law: Medicaid provides a pharmacy benefit to over 32 million beneficiaries, many of whom have other forms of health insurance. In accordance with 42 CFR 433.145, when Medicaid beneficiaries have third-party insurance, Medicaid has a legal right to payment from these sources. Consequently, Medicaid agencies must avoid costs by denying these claims from providers, who can then bill the liable third party. However, if CMS grants a cost-avoidance waiver, the Medicaid agency may “pay and chase” by paying providers up front and then seeking reimbursement from the liable third party. In these cases, the State must demonstrate that paying and chasing for third-party liability is more cost effective than cost avoidance.

Proposal (✓Procedural): CMS should determine whether States’ cost-avoidance waivers for pharmacy claims are meeting the cost-effectiveness criterion. CMS can ascertain cost effectiveness by requiring States to track dollars that they pay and chase and the amounts that they recover. CMS should also review States’ policies to determine if States are paying and chasing pharmacy claims without waivers.

Reason for Action: Thirty-two States were at risk of losing over 80 percent (\$367 million) of the Medicaid pharmacy payments that they tried to recover from third parties through the pay-and-chase approach. However, the cost-avoidance approach prevented \$185 million from being at risk in 17 other States. These findings suggest that the pay-and-chase method is not cost effective.

Savings (in Millions):

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
\$185	\$185	\$185	\$185	\$185

Status: CMS agreed that States’ cost-avoidance waivers should be reexamined. The agency is directing the regional offices to reevaluate the waivers and determine if States are paying and chasing claims without waivers. In addition, CMS is working with States that currently cost-avoid pharmacy claims and with the National Association of Chain Drug Stores in developing guidance to assist States in implementing cost avoidance.

Report:

OEI-03-00-00030 (final report, 8/01)

Administration on Aging

Use Voluntary Contributions To Expand Services for the Elderly

Current Law: Current Administration on Aging (AoA) regulations permit States to use voluntary contributions to meet cost-sharing or matching grant requirements. This use of contributions is contrary to the Older Americans Act, which requires that voluntary contributions be used to increase services for the elderly.

Proposal (✓Regulatory): AoA should revise its regulations in accordance with the Older Americans Act.

Reason for Action: According to their financial status reports, 28 States and the District of Columbia erroneously used \$90.8 million in voluntary contributions in FY 1996 and \$64.6 million in the first 6 months of FY 1999 to meet matching requirements of their grant agreements.

Savings (in Millions):

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
\$90.8	\$90.8	\$90.8	\$90.8	\$90.8

Status: AoA indicated that it has undertaken a comprehensive review of all regulations in response to the most recent reauthorization of the Older Americans Act. This review and redrafting process continues to be under development.

Report:

A-12-00-00002 (final report, 2/01)

Propose Changes to Office of Management and Budget Circular A-21 Regarding Recharge Centers

Current Law: Office of Management and Budget (OMB) Circular A-21, “Cost Principles for Educational Institutions,” requires that billing rates for specialized service funds (recharge centers) be based on actual costs, designed to recover the aggregate cost of goods or services, and reviewed periodically.

Proposal (✓*Procedural*): The Assistant Secretary for Administration and Management should propose changes to OMB Circular A-21 to improve guidance on the financial management of recharge centers. The revision should include criteria for establishing, monitoring, and adjusting billing rates to eliminate accumulated surpluses and deficits; preventing the use of recharge funds for unrelated purposes and excluding unallowable costs from the calculation of recharge rates; ensuring that Federal projects are billed equitably; and excluding recharge costs from the recalculation of facility and administrative cost rates.

Reason for Action: At 15 universities, 21 of the 87 recharge centers (1) accumulated surplus fund balances and deficits that were not used in the computation of subsequent billing rates, (2) overstated billing rates by transferring funds from center accounts or including unallowable costs in rate calculations, (3) billed users inequitably, and (4) used recharge center fund balances (surpluses or deficits) inappropriately to calculate facility and administrative cost rates. These practices resulted in overcharges to the Federal Government of \$1.9 million during FYs 1995 and 1996.

Savings (in Millions):

<u>FYs 1 & 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
\$1.9	*	*	*

**Recurring, undetermined savings would result from the circular change.*

Status: The Department concurred with our recommendations and is working with OMB on a revision to A-21. The proposed revision, which was published in the Federal Register in August 2002, would require that adjustments to a recharge center’s billing rate take into account overrecoveries/underrecoveries from previous periods. Rate adjustments would be required at least every 2 years. The final rule is expected to be issued in FY 2004.

Report:

A-09-96-04003 (final report, 3/97)

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