Partnership Plan

FEDERAL/STATE JOINT AUDITS OF THE MEDICAID PROGRAM

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Message from the Inspector General:

The Office of Inspector General (OIG) developed this Partnership Plan between Federal and State Auditors aimed at analyzing and controlling runaway Medicaid costs. The National Performance Review (NPR) represents a long-term commitment for Federal government change. In keeping with the NPR, this booklet presents the way the OIG proposes to expand audit coverage of Medicaid.

The cost of providing health care services through the Medicaid program is escalating at an alarming rate. States have felt the impact of these cost escalations as their budgets strain to continue providing health services included in the Medicaid State plans. Between 1984 and 1993, total Medicaid expenditures increased by 355 percent. During this same period, states' share of these expenditures increased by 238 percent.

Controlling Medicaid costs is an objective of both State governments and the Federal government. This partnership provides broader audit coverage and leads to a more effective, efficient and economical use of audit resources. To assure that the partnership is successful, the OIG is ready to provide States with technical assistance, audit guides, and computer programs as necessary.

Copies of this booklet are being provided to the State Governors, State Auditors, State Attorneys General, Health Care Financing Administration and other interested parties.

June Gibbs Brown
Inspector General

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SECTION I

PARTNERSHIP PLAN

PARTNERSHIP PLAN
FEDERAL/STATE JOINT AUDITS
OF THE MEDICAID PROGRAM

OBJECTIVES

The cost of providing medical care continues to escalate at an alarming rate. State governments have felt the impact of these cost increases as health care budgets strain to continue providing mandatory and optional services included in the Medicaid State plans. Innovative actions are needed to help control these runaway medical costs.

The objectives of this booklet are to:

- highlight a partnership plan for joint Federal/State audits that can positively influence the control of Medicaid costs,
- present successful OIG Medicare and Medicaid reviews and issues that will serve as a starting point for the partnership, and
- solicit ideas that will contribute to the success of the partnership.

Forming a Federal/State partnership for auditing the Medicaid program will provide broader audit coverage of significant issues and lead to a more effective, efficient and economical delivery of health care services and use of audit resources.

The thrust of this proposed partnership plan is not intended to identify and recommend recovery of unallowable costs from

State agencies. Rather, it is envisioned that the partnership will focus on issues that will result in program improvements and reduce the cost of providing needed services to Medicaid recipients.

The **first section** of this booklet provides general information on the Office of Inspector General, State Auditors and the Medicaid program. It also describes the proposed Federal/State audit partnership, how that partnership can work to benefit the Federal and State governments and how the joint projects can be coordinated between the OIG and State Auditors.

The **second section** of this booklet is a compilation of suggested audit issues for potential joint projects. The compilation is organized by type of service, and within each type of service, by completed audits and developing issues. Each suggestion has a brief narrative describing the issue and, where applicable, the methods used and results achieved.

BACKGROUND

OFFICE OF INSPECTOR GENERAL

The mission of the OIG is to improve programs and operations of the Department of Health and Human Services (HHS) and to protect them against fraud, waste, and abuse. By conducting independent and objective audits, evaluations, and investigations, the OIG provides timely, useful, and reliable information and advice to HHS officials, the Administration, the Congress, and the public.

The Office of Audit Services (OAS), one component of the OIG, provides all auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work

done by CPA contractors. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities. These audits are intended to provide independent assessments of HHS programs and operations in order to reduce waste, abuse, and mismanagement and to promote economy, efficiency and effectiveness throughout HHS.

The Health Care Financing Audits Division is one of the program-oriented components within OAS. This group, headed by an Assistant Inspector General, is responsible for planning, organizing, and monitoring all audits involving the Medicare and Medicaid programs. Health care audits are aimed at:

- encouraging more efficient and cost effective delivery of health care to elderly, disabled and indigent Americans;

- being responsive and oriented to health care policy and program officials' needs for up-to-date information on critical health care issues;

- providing high quality technical and innovative support for proposed regulatory reform and policy changes;

- reviewing the Health Care Financing Administration's (HCFA) operations to help ensure that mandated program requirements are fulfilled by using available resources in the most cost effective and efficient manner;

- detecting and reducing fraud, waste, and abuse in HHS' health care programs and operations;

- recommending corrective actions on identified problems in the Medicare and Medicaid programs and ensuring that corrective actions were taken; and

- upholding the OIG's oversight responsibilities to help protect the integrity of the health insurance trust funds.

Changing Audit Focus From the Past to the Future...

Traditionally, OIG auditors performed retrospective, compliance-type reviews of the Medicaid program. These included reviews of State agencies' implementation of, and compliance with, State plan provisions. The reviews often identified significant amounts of unallowable costs with recommendations that the particular State government return funds to the Federal Treasury.

Over the past year, the OIG has begun a move toward prospective-type reviews in order to determine whether current and proposed health care policies are reasonable and equitable and provide for access to reasonable, quality care. Our reviews have also focused on identifying future savings related to changes in health care policies and Medicaid State plans.

STATE AUDITORS

State governments are faced with the same problems as the Federal government--the number and cost of programs continue to grow. As a result, State Auditors must step up to meet the increased demands to ensure accountability to the public, State officials and State legislatures. To meet these demands, the missions of State Auditors include assurances that government funds are handled properly, in accordance with laws and regulations, and in an economical and efficient manner. Further, users of State Auditors' reports are increasingly interested to know that agencies, programs and services are accomplishing their intended purposes.

The legal basis for State Auditor offices is constitutional, statutory or both. The organization, method of operations, scope of work and audit coverage differ greatly from state to state.

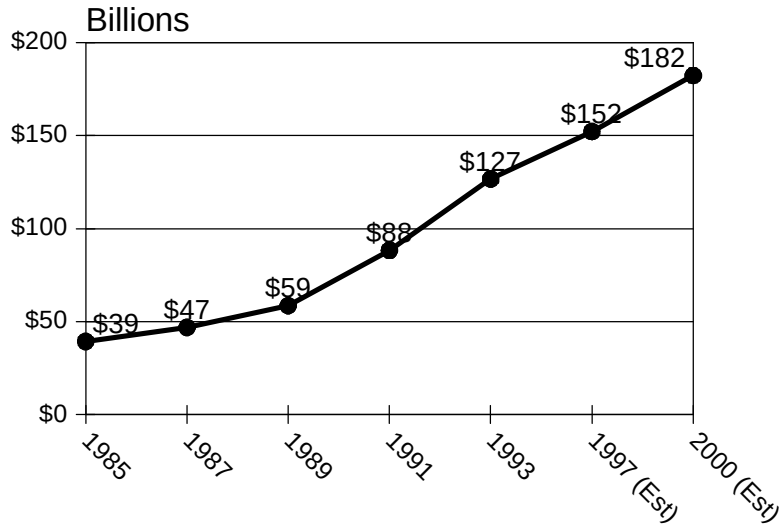
Majority Perform Financial and Performance Audits...

While a few States limit the types of audits performed to single audits and financial statement audits, the majority of State Auditors perform both financial and performance audits.

THE MEDICAID PROGRAM

The Medicaid program was enacted in 1965 as Title XIX of the Social Security Act and provides health insurance coverage for certain individuals and families with low incomes. It is a program financed by Federal and State funds, currently providing health benefits for 27 million low-income Americans. Medicaid covers extensive medical services for its recipients, including nursing home care, hospital and home health care, prescription drugs, and physician services.

Actual and Projected Medicaid Expenditures 1985 - 2000



The Medicaid program is operated by the States with Federal oversight from the Department of Health and Human Services. Medicaid outlays have risen at a dramatic pace, causing Medicaid spending to become the fastest rising portion of the Federal and State budgets. In Federal fiscal year 1993, Medicaid spending increased 11 percent to $126.6 billion ($72.6 billion Federal share and $54 billion States' share). Since 1984 Medicaid expenditures have increased 355 percent. It is expected that these expenditures will reach $152 billion by 1997 and will exceed $180 billion by the year 2000.

The Federal and State governments are concerned about the skyrocketing rate of Medicaid spending, and their budgets are overburdened with increased expenditures. There has been increased interest in the Medicaid program in both the private and public sectors. There is a consensus that current spending trends are unsustainable, for the Federal and State governments. Accomplishing the missions of Federal and State Auditors can play an important role in changing the current spending trends.

THE PARTNERSHIP

METHODOLOGY

As the Medicaid program experiences a tremendous rate of growth, innovative actions are needed to help achieve the missions of Federal and State Auditors. One such action is to form a partnership between the OIG and State Auditors to analyze runaway Medicaid costs. Initially, the partnership will work in three different ways.

Joint Projects...

First, the partnership would involve the OIG and State Auditors working jointly on projects which would have mutually beneficial results. Reviews of programmatic aspects of the Medicaid program would lead to (1) joint audit recommendations for savings at both the Federal and State levels, and (2) improvements in internal controls and computer system operations. Because State Auditors have different mandates, the joint projects can be designed as flexibly as necessary to meet the different requirements in each State and to avoid hindering State Auditors' work plans.

OIG Shares Methods and Results With State Auditors...

Second, the partnership would involve the OIG sharing with State Auditors the methods used and the results achieved in past Medicare and Medicaid audits. This information may provide State Auditors with leads for audits of health care provider operations and Medicaid agencies' systems for paying the health care providers.

State Auditors Share Methods and Results With OIG...

Third, and equally important, the partnership would involve State Auditors sharing their audit methods and results with the OIG. This will enable the OIG to assess the potential nationwide impact of cost saving recommendations implemented by States. It may also provide needed support for Federal recommendations made, but not implemented.

The results of the partnership with State Auditors could lead to the identification of legislative changes that the State and Federal governments could consider to help build efficiencies into the Medicaid service delivery system. Discussions on these changes may involve legislative staff meetings, and legislative hearings, at both the Federal and State levels.

For some audits, it will be best for the OIG and State Auditors to work together because one or the other will have already completed audit work in the subject area. These types of joint audits could lead to dollar recoveries for past overpayments and/or identification of future cost savings. Amounts recovered from providers would be returned to the Federal and State governments on the basis of each particular State's Federal Medical Assistance Percentage, resulting in a beneficial situation for both. Recommended procedural changes, if implemented, should preclude similar problems from occurring in future periods.

For other audits, the issues have not been fully developed. The scope and methodology need to be developed through interaction between the OIG and State Auditors. Many of these issues relate to conditions found in audits of the Medicare program and audits of selected Medicaid agencies.

Audits Performed in Medicare are Applicable to Medicaid

The OIG has been successful in auditing the Medicare program and identifying areas of inefficiencies in the health care delivery system. Recommendations from these audits have resulted in system improvements, and recoveries and savings for the Medicare trust fund. Many of these Medicare issues and recommendations could apply to Medicaid programs. Additionally, the OIG has audited Medicaid services in selected State agencies. These issues could also apply to other Medicaid agencies.

Medicaid Database Assists in Identifying Issues

To assist in identifying potential audit issues in Medicaid, the OIG has a nationwide Medicaid database. For each State and Medicaid service, the database contains total Medicaid expenditures, the Federal share of those expenditures and the related number of recipients of Medicaid services. The database currently has information for Medicaid services beginning with Federal fiscal year (FFY) 1984 and ending with FFY 1994.

The database information, used in conjunction with appropriate sections of State plans, assists in identifying those areas that may be at risk. A survey of the potential problem area will quickly determine if further audit work is needed.

Forming a Federal/State partnership for auditing the Medicaid program will provide broader audit coverage of significant issues and lead to a more effective, efficient and economical delivery of health care services and use of audit resources. These objectives of the partnership are achievable and can result in significant benefits to the Federal and State governments.

BEGINNING THE PARTNERSHIP

We have already succeeded in forming partnerships with State Auditors/Comptrollers. The Louisiana Legislative Auditor, with our assistance, built on work previously performed by the OIG in the Medicaid Drug Rebate program and issued a report recommending corrective actions to the State Medicaid agency. The North Carolina State Auditor and the OIG also jointly issued a report on a similar review. The New York State Comptroller and the OIG are currently working to establish continuing Medicaid/Medicare data matches so that inappropriate payments to vendors for services rendered for dually eligible beneficiaries can be readily identified.

The OIG has also worked with the National State Auditors Association on a nationwide review of the Medicaid Prescription Drug Program in eight participating States: Maryland, Delaware, Iowa, Michigan, Missouri, Ohio, Texas and Utah. The Maryland State Auditor is the lead on this project which involves reviews of: Drug Rebates, Generic Drugs, Ulcer Treatment Drugs and Mail Order Drugs. Individual State Auditors have issued their reports and a consolidated report is expected sometime in 1995.

Most recently, the OIG has initiated a highly productive joint project with the Massachusetts State Auditor. This project stems from the OIG's success with similar reviews in the Medicare program. The objective of the project is to determine the propriety of payments made by the Massachusetts State Medicaid agency to providers of clinical laboratory tests. Computer applications have identified a significant number of potential overpayments for laboratory services paid during 1992 and 1993. The OIG is currently working with the Massachusetts State Auditor to quantify the total amount of overpayments and a report will be issued shortly.

This project has also been expanded to include other States. We are currently working with the Louisiana Legislative Auditor on a joint review of laboratory services. We are also working with the Texas State Auditor on a review of laboratory services, Prospective Payment System hospital transfers and non-physician services. Further, we will be contacting other State Auditors to invite them to participate in joint audits of laboratory services.

PARTNERSHIP COORDINATION--OIG CONTACT

The Health Care Financing Audits Division will spearhead the partnership plan within the OIG. Individuals assigned to health care work in OIG Regional and Field Offices throughout the nation will also be available to assist State Auditors in several capacities. These include working with State Auditors on joint audits, providing advice and guidance on health care issues and audit methodology, providing advanced techniques assistance and serving as a local liaison with the State Auditors.

The OIG welcomes any suggestions you may have for joint audits, and also solicits any ideas for audits/reviews which you believe the Office of Audit Services should perform.

Comments or questions regarding information in this document and/or suggestions for additional audit issues may be directed on a national basis to:

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NEW YORK **(212) 264-4620**	**John Tournour, Regional Inspector General for Audit Services** **26 Federal Plaza, Room 3900A** **New York, NY 10278**
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SAN FRANCISCO **(415) 556-5766**	**Lawrence Frelot, Regional Inspector General for Audit Services** **50 United Nations Plaza, Room 171** **Federal Office Building** **San Francisco, CA 94102**

SECTION II

POTENTIAL JOINT AUDITS FOR FEDERAL/STATE PARTNERSHIP

PREFACE

Section II is a compilation of past OIG Medicare and Medicaid reviews and other issues that are suggestions for potential joint audits. We have included Medicare audits and developing issues that we believe to be relevant to State Medicaid programs. These suggestions are organized by type of service, and within each type of service, by completed audits and developing issues. A brief narrative description and, when applicable, the methods used and the results achieved are included for each suggestion. You will note that not all the areas are completed with multiple reviews. We are very interested in receiving from State Auditors any additional areas that you have completed reviews in and/or any issues that you believe we at the Federal level should pursue.

The suggested issues were selected to provide audits that could be completed with minimum audit resources and that could have potentially significant results. Not all of these issues will have high dollar amounts in a particular State. However, we are in the process of screening available information to help us focus on more significant issues in a particular State. For many of these suggestions, a brief review of the Medicaid State plan would also determine if the issue is relevant to a particular State.

The OIG would be pleased to provide technical assistance, audit guides and computer programs as necessary. The extent of assistance from the OIG rests exclusively with each State Auditor.

Requests for specific information concerning potential audits listed in this booklet should be directed to:

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OR

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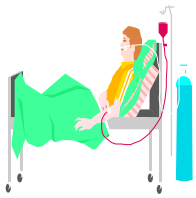
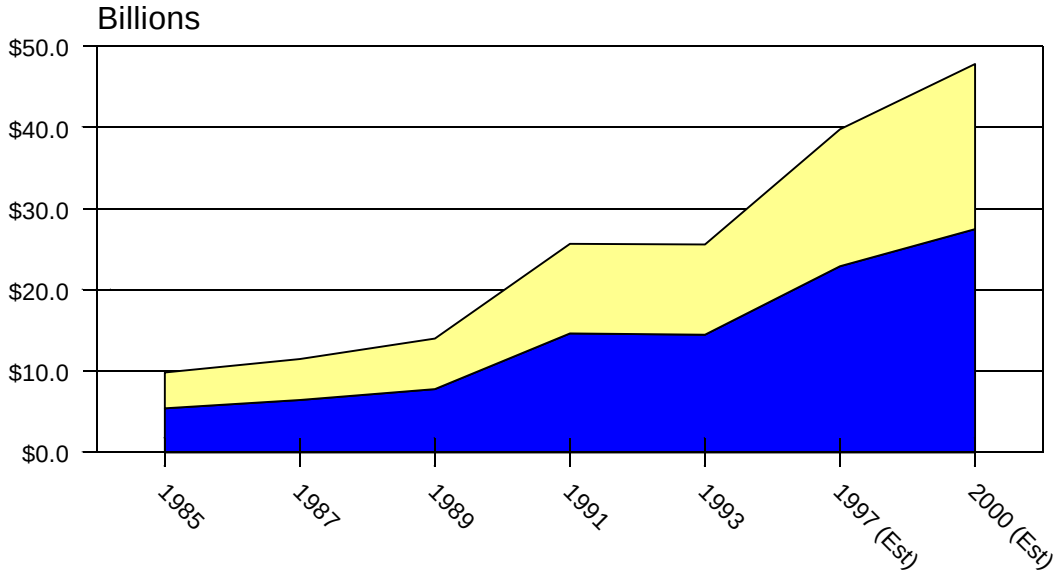
NARRATIVE DESCRIPTION OF COMPLETED AUDITS AND DEVELOPING ISSUES



INPATIENT HOSPITAL SERVICES



State	$4.4	$5.1	$6.2	$11.1	$11.1	$16.9	$20.3
Federal	$5.4	$6.4	$7.8	$14.6	$14.5	$22.9	$27.5
Total	$9.8	$11.5	$14.0	$25.7	$25.6	$39.8	$47.8

INPATIENT HOSPITAL SERVICES

☞ 1993 TOTAL MEDICAID OUTLAYS - $25.6 BILLION

COMPLETED AUDITS

Improper Coding for Prospective Payment System (PPS) Transfers

Under the Medicare program, hospitals that admit, stabilize and transfer patients to other hospitals generally use fewer resources than hospitals providing the full scope of medical treatment. Therefore, a hospital transferring a Medicare patient to another prospective payment system (PPS) hospital receives a per diem payment based on the diagnosis-related-group (DRG) amount. The receiving hospital is paid the full amount of the DRG. A transfer improperly reported as a discharge usually results in an overpayment because both hospitals receive the full DRG amount.

The Office of Inspector General (OIG) recently completed a joint project with the Health Care Financing Administration (HCFA) and the Medicare Intermediaries. Our project focused on overpayments to hospitals reimbursed under the Medicare PPS. Our objectives were to identify a universe of improperly reported PPS hospital transfers and to work with the HCFA and the intermediaries to recover the overpayments associated with these transfers.

The OIG provided HCFA and its intermediaries with about 123,000 PPS transfer transactions with potential overpayments covering the period January 1986 through November 1991. The intermediaries, with assistance from HCFA and the OIG, have recovered about $219 million of overpayments for the Medicare Part A Trust Fund. In addition, implementation of recommended improvements to the PPS transfer edits resulted in annual savings totaling $8.1 million. These transfer overpayments occurred because Medicare claims for patient transfers between PPS hospitals were erroneously coded and paid as discharges.

Controls Over the Billing for Nonphysician Outpatient Services

Under the Medicare PPS, Medicare fiscal intermediaries reimburse hospitals a predetermined amount for inpatient services depending on the illness and its classification under a DRG. As implemented by the HCFA, separate payments for nonphysician, outpatient services provided on the day before admission to the same hospital or during an inpatient stay, exclusive of the day of discharge, are not permitted. Effective January 1, 1991, the Omnibus Budget Reconciliation Act of 1990 expanded the DRG payment window to 72 hours immediately preceding the day of the patient's admission.

The OIG recently completed a review of separate payments for nonphysician, outpatient services provided prior to admission to hospitals under the PPS. The costs for these services are included in the DRG payment and should not be billed separately. The objectives of our review were to (1) determine if necessary controls were in place to preclude payment of nonphysician, outpatient services in accordance with Medicare law and regulations, and (2) identify any improper payments made to PPS hospitals.

Based on computer matches of general care hospital, inpatient claims data with nonphysician, outpatient claims data for the period November 1990 through December 1991, we estimate that:

- about $7.9 million* in improper payments for nonphysician, outpatient services were made to PPS hospitals; and

- Medicare beneficiaries were charged about $3.9 million* for the coinsurance and deductible applicable to these improper payments.

These improper payments were made because of clerical errors, separate billing departments, billing systems not compatible with the DRG payment window, and insufficient or nonexistent edits at the fiscal intermediaries. Recommendations were made to correct the deficiencies noted.

Full Payment of a DRG Amount When the Patient Did Not Stay Overnight

Since the inception of the Medicare PPS system, there have been concerns over its financial impact on hospital operations. Two of these concerns pertain to inherent incentives under the PPS reimbursement methodology. Because hospitals receive the full DRG payment for any inpatient admissions, it is beneficial for the hospital to increase the number of admissions. As admissions increase, the potential for medically unnecessary admissions increases. It is also beneficial for hospitals to minimize costs associated with the established revenue for a DRG.

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* Estimates are based on results to date. These figures will change based on responses not yet received from fiscal intermediaries.

An inpatient admission is defined, under Medicare reimbursement principles, as an inpatient visit which is expected to require an overnight stay. The objective of our review was to evaluate the propriety of the Medicare reimbursement for inpatient hospitalizations that did not require an overnight stay.

We found that hospitals are realizing substantial revenues in excess of charges for admissions that did not require an overnight stay. Because PPS reimburses on a per discharge basis, it can be more beneficial to admit a patient rather than find an alternative means of providing services. Although we did not discover any hospital willfully circumventing admission criteria, we noted several admissions of doubtful necessity. In addition, for those cases where the patient was discharged because of canceled surgery, a subsequent admission may occur and another DRG reimbursement to the hospital could be made.

In other cases, when few, if any, services were provided (voluntary patient discharge, patient death), the designation as a hospital admission with the resulting payment of a full DRG amount does not appear reasonable. Our review concluded that the Medicare program could realize a savings of approximately $118 million annually by changing the reimbursement methodology for those inpatient hospitalizations that do not require an overnight stay.

Identification and Collection of Credit Balances in Patient Accounts

A Medicaid credit balance at a hospital occurs when reimbursements for services provided to a Medicaid recipient exceed the amount due the provider according to its accounting records. Federal regulations outline provisions which State agencies must follow for claims payment when a third party is liable. In most cases, the Medicaid program has payment liability only for that portion of the patient's bill not covered by third party resources, such as health or accident insurance,

workers' compensation, Veterans Affairs, Medicare, or other primary coverage.

When a third party and the Medicaid program both pay for the same services, a Medicaid credit balance is created and is reflected on the patient's ledger account at the hospital. Other causes of Medicaid credit balances are Medicaid payments in excess of the amount due and duplicate Medicaid payments for the same services.

Our review of 64 hospitals in 8 States showed that not all hospitals were reviewing their credit balances in a timely manner. As a result, Medicaid overpayments were not always returned to the State agency. Based on our review, we estimate that the 64 hospitals had received Medicaid overpayments totaling $1.79 million ($1.01 million Federal share and $.78 million State share) which should have been refunded prior to our review. Projecting the preliminary results of our review nationwide, we estimate that hospitals have received and retained an estimated $73.4 million ($42 million Federal share and $31.4 million State share) in Medicaid overpayments.

We found that the two main causes for Medicaid overpayments were (1) the services had been reimbursed by another insurer as well as Medicaid or (2) the provider had submitted duplicate claims for the same services.

DEVELOPING ISSUES

Hospital Patient Dumping

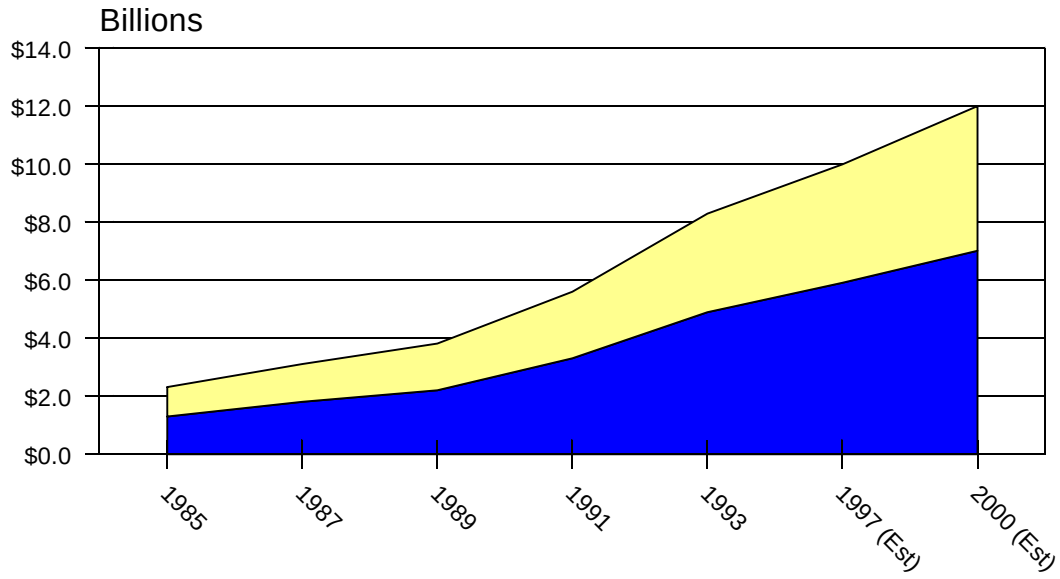
Many State Medicaid agencies have implemented hospital reimbursement systems similar to the Medicare system--a prospective system based on DRGs. Normally the hospitals would receive an established payment amount for each hospital

stay. Transferring or discharging a patient in an unstabilized condition, referred to as patient dumping, results in the hospital maximizing reimbursement amounts and/or avoiding costly hospital stays. This issue would focus on determining the adequacy of State agencies' policies and procedures to assure that hospitals are not engaging in patient dumping.

Duplicate Medicaid and Veterans Affairs (VA) Hospital Payments

Veterans eligible for Medicaid services can also be eligible for hospital care provided by the VA. In instances where VA authorizes care at a non-VA hospital, the potential exists for duplicate reimbursements by Medicaid and VA. This issue would focus on identifying duplicate payments to hospitals for Medicaid recipients eligible for VA benefits.

PRESCRIPTION DRUG SERVICES



State	$1.0	$1.3	$1.6	$2.3	$3.4	$4.1	$5.0
Federal	$1.3	$1.8	$2.2	$3.3	$4.9	$5.9	$7.0
Total	$2.3	$3.1	$3.8	$5.6	$8.3	$10.0	$12.0

Federal State

PRESCRIPTION DRUG SERVICES

☞ 1993 TOTAL MEDICAID OUTLAYS - $8.3 BILLION

COMPLETED AUDITS

Accountability for and Controls Over Drug Rebates Due, Received and/or Disputed

With the implementation of the Medicaid drug rebate program, numerous questions have arisen concerning the financial accountability and proper reporting of drug rebates. To determine if States have had problems implementing a financial management system over Medicaid drug rebates, we initiated a nationwide review.

Information from our on-site reviews in eight States showed weaknesses in internal controls and adjudication of drug rebates in dispute. The States had not established adequate accountability over drug rebates. The amounts of the rebates due from manufacturers and amounts in dispute were not always known, and little documentation of efforts to resolve disputes was maintained.

Some of our more significant findings were (1) States did not maintain a general ledger accounts receivable control for manufacturer drug rebates; (2) drug rebates deposited were not balanced to the log of rebate payments received; (3) restrictive endorsements were not placed on each incoming check upon receipt; (4) aggregate rebate collections were not reconciled against postings to individual receivable accounts; and (5) State agencies did not have policies and procedures for adjudicating drug rebate disputes within 60 days of a discrepancy notification

by drug manufacturers or for write-off/reductions of rebate receivables.

Our review clearly indicated that States have had problems in implementing a financial management system over Medicaid drug rebates. While the States collected about $235 million in rebates in 1991, based upon our reviews of the Medicaid drug rebate program, we estimated that there could be significantly more rebates in dispute.

Limiting the Prescribing of Ulcer Treatment Drugs to Dosages Recommended by Manufacturers

The Omnibus Budget Reconciliation Act of 1990 requires State Medicaid agencies to operate drug utilization review programs on an ongoing basis. These programs are intended to assess patient drug use against predetermined standards. One of these standards is the manufacturers' recommended dosages. The assessment should monitor therapeutic appropriateness, over-utilization, and incorrect drug dosage or duration of drug treatment.

We performed a review to estimate the potential Medicaid savings by limiting the reimbursement for ulcer treatment drugs to the manufacturers' recommended dosages. We randomly selected 200 Medicaid patients who received ulcer treatment drugs from each of eight randomly-selected States. We reviewed reimbursement records for the resulting 1,600 Medicaid recipients who received ulcer treatment therapy through at least one of six ulcer treatment drugs.

The ulcer treatment drugs include Tagamet, Zantac, Pepcid, Axid, Carafate, and Prilosec (formerly Losec). The manufacturers of these six ulcer treatment drugs recommend an active treatment period of up to 8 weeks. The manufacturers recommend significant dosage reductions--at least 50 percent reductions--after the active treatment period. There are

circumstances in which the active treatment dosages must be continued beyond the 8-week period. Because these circumstances are unusual, we did not attempt to quantify the rate of incidence or the dollar effect of the extended therapy.

Of the 1,600 Medicaid recipients that we reviewed, 606, or 38 percent, of the recipients received dosages in excess of the manufacturers' recommendations. We compared the amounts reimbursed for these 606 recipients with the amounts that would have been reimbursed had the dosages been consistent with manufacturers' recommendations. Using this comparison, we computed a potential cost savings of $116,133 for 1990 for these recipients. We estimate that national savings would be about $112 million annually.

Medicaid Savings Through the Use of Therapeutically Equivalent Generic Drugs

Under Medicaid, reimbursement for drugs is generally based upon ingredient costs plus a reasonable pharmacy dispensing fee. Effective October 29, 1987, Federal regulations limited the amount which Medicaid reimbursed for drugs with available generic substitutes to a Federal upper limit price (FULP). This upper limit amount is 150 percent of the lowest priced generic equivalent drug that is available plus a reasonable dispensing fee. The HCFA is responsible for identifying and publishing a list of the drugs with FULPs.

Under Federal regulations, States have the flexibility to pay more for some upper limit drugs and less for others. However, States' claims for Federal financial participation cannot exceed the aggregate of the individual FULP for all upper limit drugs. Additionally, FULP limits do not apply to drug purchases where prescribing physicians certify in their handwriting on the prescription form that a specific brand is medically necessary. Physicians are not required to provide any specific medical, scientific, or diagnostic information regarding their brand name

decisions. The payment limits for brand name drugs are based on estimated acquisition costs of the drugs rather than the FULP amount and are usually higher than the FULP amount.

We performed a review to study (1) efforts taken by State Medicaid programs and selected private and public health benefit programs to encourage the use of less costly generic prescription drug products and (2) the financial impact of changing Federal regulations to limit reimbursement of brand name drugs to the amounts set by the HCFA for equivalent generic drugs.

We found that 11 State Medicaid programs have policies in place that promote the use of generic drugs beyond the current Federal requirements. We also found that use of generic drugs was being promoted by other programs that provide health benefits. Some programs require generic substitution when generic drugs are available, while others use financial incentives as part of their reimbursement policy.

We calculated that the annual cost savings to the Medicaid program could be as much as $46 million for only 37 high volume dispensed brand name drugs. The cost savings will become even greater in the future as the Federal patents on 60 important, highly used drugs expire between now and 1995.

DEVELOPING ISSUES

Average Wholesale Price Exceeds Actual Average Invoice Price

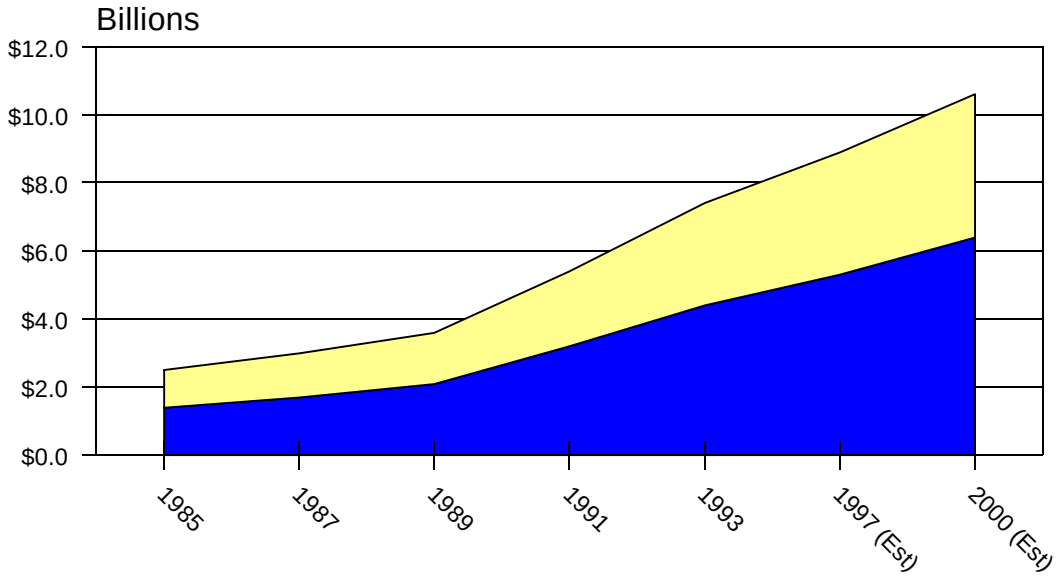
Most States reimburse pharmacies for Medicaid prescriptions using a formula which discounts a certain percentage of the Average Wholesale Price (AWP). The Omnibus Reconciliation Act of 1990 prohibits changing Medicaid reimbursement to

pharmacists for 4 years. Because States will be authorized to reduce payments to pharmacies once the 4-year moratorium expires on December 31, 1994, States will show a renewed interest in information which will indicate the extent to which AWP tends to exceed average actual invoice prices. Determining the size of the spread between AWP and actual invoice prices will help States decide about changes to their formulas. These changes could result in significant savings for the prescription drug programs.

Medicaid Drugs - Mail Order Delivery System for Maintenance Drugs

Establishing statewide mail order systems for Medicaid outpatient prescription drugs could provide maintenance drugs for Medicaid recipients effectively and more economically. A study of States' prescription drug programs should provide the data necessary to determine the feasibility of establishing a mail-order system. Recommendations for policy changes which would alter the drug delivery system should consider the effect of Medicaid recipients' access to drugs needed for emergency care.

PHYSICIAN SERVICES



State	$1.1	$1.3	$1.5	$2.2	$3.0	$3.6	$4.2
Federal	$1.4	$1.7	$2.1	$3.2	$4.4	$5.3	$6.4
Total	$2.5	$3.0	$3.6	$5.4	$7.4	$8.9	$10.6

PHYSICIAN SERVICES

☞ 1993 TOTAL MEDICAID OUTLAYS -- $7.4 BILLION

COMPLETED AUDITS

Establish Mandatory Prepayment Edit Screens to Detect Unbundled and Mutually Exclusive Procedure Codes

Under the Medicare and Medicaid programs, the amount of reimbursement to a physician depends largely on the type of service performed and the manner in which the service is coded on the bill. The HCFA requires physicians to use HCFA's Common Procedure Coding System to describe the services being billed to Medicare and Medicaid. This system is an offshoot of the Current Procedural Terminology (CPT-4) coding system that was developed by the American Medical Association in 1966. There have been numerous criticisms of the CPT-4 coding system as being overly detailed and allowing physicians too much latitude in billing.

We conducted a review of a sample of claims paid by a Medicare carrier and a State Medicaid agency for the 2-week period, April 9, 1990 to April 20, 1990. The purpose of our review was to identify inappropriate billings made by physicians. The analysis of billings was performed by an independent contractor for the OIG. Those claims identified as having a potential billing problem were analyzed for accuracy by a physician reviewer. The contractor then supplied the OIG with its preliminary results, which indicated that the incorrect use of procedure codes by physicians may be costing Medicare and Medicaid millions annually.

Our contractor's comprehensive edit system identified potential Medicare overpayments of $463,397 and Medicaid overpayments of $25,712 for the 2-week period. This would result in overpayments of $12.9 million annually for the one Medicare carrier and the one State Medicaid agency.

We recommended that HCFA move swiftly with the process of establishing mandatory prepayment edit screens for the Medicare and Medicaid programs. To assist HCFA in its effort, we invited its representatives to join the OIG/State agency validation team in the review of our contractor's edit system.

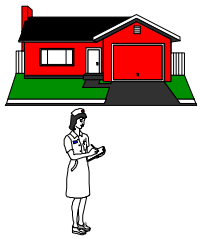
The incorrect use of procedure codes by physicians can result in unnecessary expenditures for the Medicaid program. This issue could be reviewed jointly by OIG and State Auditors to identify whether improvements in claims processing in the State Medicaid system are needed.

DEVELOPING ISSUES

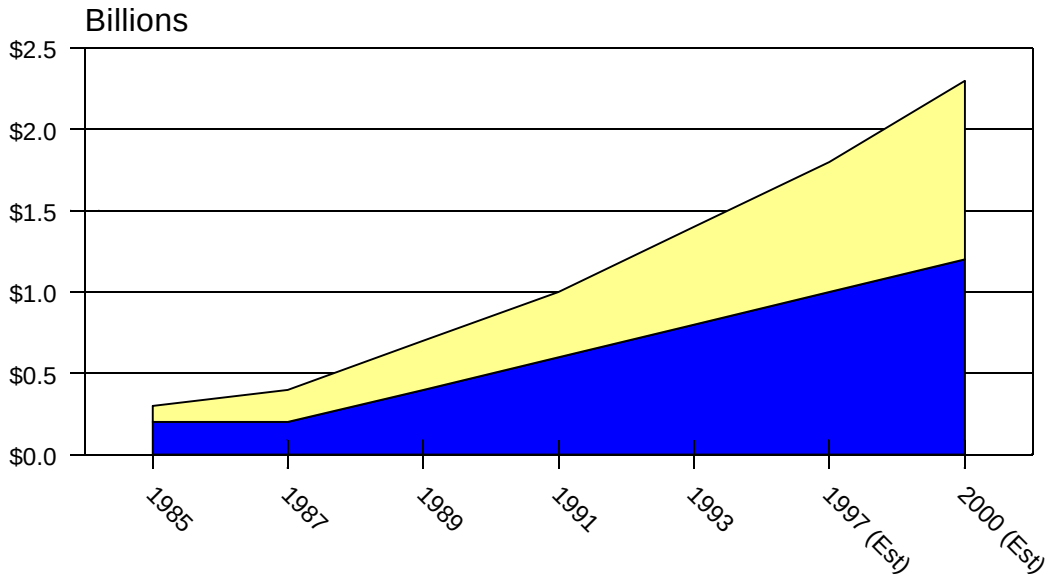
Physician Billing Practices

This review is designed to examine provider billing practices for office visits to search for over-utilization and inappropriate levels of care being billed. Computer programs could be developed to profile provider billings for office visits and identify providers with questionable billing patterns. High volume providers would be targeted for site visits and medical record examination.

Computer programs could also be used to analyze cardiology services. These programs would focus on detecting over-utilization by cardiologists. The review could include such services as EKGs, pacer checks, single- and multi-event recordings, 24-hour monitors, cardiac rehabilitation, stress tests and echocardiography.



HOME HEALTH AGENCY SERVICES



State	$0.1	$0.2	$0.3	$0.4	$0.6	$0.8	$1.1
Federal	$0.2	$0.2	$0.4	$0.6	$0.8	$1.0	$1.2
Total	$0.3	$0.4	$0.7	$1.0	$1.4	$1.8	$2.3

Federal State

HOME HEALTH AGENCY SERVICES

☞ 1993 TOTAL MEDICAID OUTLAYS -- $1.4 BILLION

COMPLETED AUDITS

Physician's Role in the Delivery of Home Health Services

Home health care allows people with limited mobility to live independently, while still receiving professional health care services. In order for home health services to be paid for by Medicare, certified home health agencies (HHAs) must provide skilled nursing services or physical, speech, or occupational therapy to homebound beneficiaries. Additionally, a physician must sign a certification that he has reviewed and approved a home-based plan of care, and that the patient is homebound. Patients must also have rehabilitation potential.

Virtually all Medicare reimbursements for home health care are made under Part A, hospital insurance. Unlike most other Medicare providers paid under a prospective payment system, HHAs are currently reimbursed on a cost basis. There is no limit on the number of visits that a beneficiary may receive.

We performed an audit to determine whether payments to HHAs in one State have met Medicare reimbursement requirements. Specifically, we determined whether payments were for services: (1) provided to beneficiaries, (2) properly authorized by a physician, and (3) needed by the beneficiaries.

Our review showed that the Medicare program is paying for unallowable home visits because physicians are signing certification forms without having a current, first-hand knowledge of the medical conditions of the beneficiaries. We found that the HHAs are determining the type and frequency of the services to be provided, completing the form and then obtaining a physician's signature. As a result, medically unnecessary services are being provided to patients who are not homebound, and to patients with no rehabilitation potential.

Based on these early results, we believe that Medicare could help assure more appropriate care, as well as, achieve substantial program savings, by implementing controls requiring the physician who signs the certification forms to have current, first-hand knowledge of the medical conditions of the Medicare beneficiaries receiving the care. As such, the physician would be able to develop appropriate plans of treatment which meet the specific medical needs of Medicare beneficiaries.

DEVELOPING ISSUES

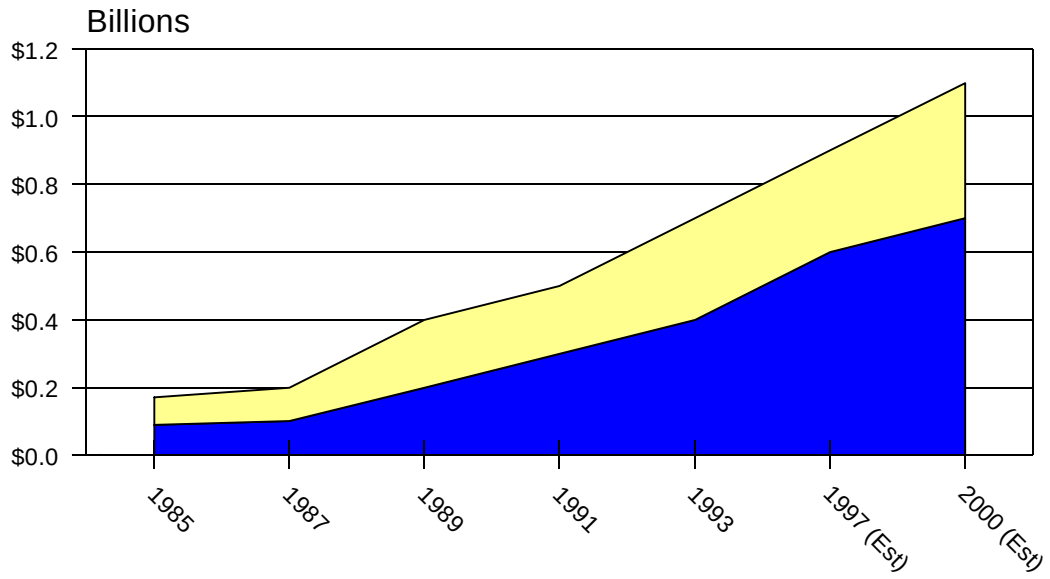
Medicaid Fraud and Abuse in Home Health Agencies

Home health care services include nursing care, personal aid services, durable medical equipment and home infusion therapy. The cost of home health care services is rapidly increasing. Medicaid expenditures for these services rose to $1.4 billion in 1993 and are expected to reach $1.85 billion in 1997. Recent news articles report that fraud and abuse plague the home health care industry. Surveys to identify high-risk areas subject to fraud and abuse should provide high-profile, high-yield audit areas.

Review of Home Health Services Claims

Our review of claims submitted by home health agencies will determine whether services claimed were: (1) actually provided to eligible recipients; (2) properly authorized; and (3) needed by recipients. Our review will also include an analysis of subcontracting arrangements and related party transactions. We are currently conducting a pilot review of these areas at one home health agency and will expand the review nationally.

LABORATORY AND RADIOLOGY SERVICES



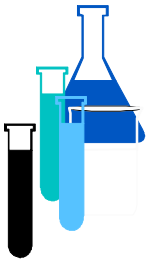
State	$0.1	$0.1	$0.2	$0.2	$0.3	$0.3	$0.4
Federal	$0.1	$0.1	$0.2	$0.3	$0.4	$0.6	$0.7
Total	$0.2	$0.2	$0.4	$0.5	$0.7	$0.9	$1.1

LABORATORY AND RADIOLOGY SERVICES

☞ 1993 TOTAL MEDICAID OUTLAYS -- $715.6 MILLION

COMPLETED AUDITS

Unbundling of Laboratory Services Reimbursed by Medicare



Part B of Title XVIII of the Social Security Act (Medicare Supplementary Medical Insurance), as amended, covers clinical laboratory services performed at hospitals, physicians' practices, or independent laboratories. Claims for clinical laboratory services are reimbursed based on a Medicare fee schedule and are subject to guidelines published by the Medicare program. Medicare pays 100 percent of the fee schedule amount or the actual charge (whichever is lower) for the laboratory service provided that the service is reasonable and necessary for the diagnosis or treatment of an illness or injury.

The objective of our review was to determine the adequacy of procedures and controls over the processing of Medicare payments for clinical laboratory tests performed by hospitals, physicians' practices, or independent laboratories. Our review was limited to those clinical laboratory tests which measure the chemical and hematological composition of blood.

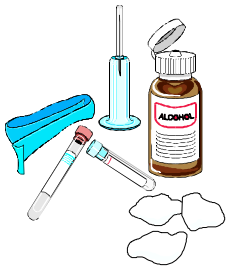
Based on computer matches of hospital claims for outpatient services in 1991, we estimated that hospitals in one State were

overpaid $2.25 million for chemistry and hematology tests. In the same State, computer matches of claims submitted by physicians and independent laboratories in 1992 identified overpayments totalling $426,817.

These overpayments were made because adequate controls were not in place to ensure proper payment of chemistry and hematology claims when more than one test was performed on behalf of a Medicare beneficiary. Specifically, we found that the payment process did not detect claims for chemistry tests that should have been grouped together (bundled into a panel) for payment purposes. Further, the system was not able to detect and prevent payment of duplicate claims for chemistry and hematology tests. We found that duplicate payments were made for tests that were either claimed under more than one panel or claimed as part of a panel and also as individual tests.

Recommendations were made to (1) install edits to detect and prevent overpayments for unbundled or duplicate charges for chemistry and hematology tests performed by hospitals, physicians and independent laboratories and (2) initiate recovery of overpayments made to providers.

Limit Payments for Panel and Profile Tests to the Sum of the Payment Allowances for the Component Tests



Medicare guidelines state that fee schedule amounts for panel and profile laboratory tests should not be greater than the fee schedule amounts for the component tests included in the panels and profiles.

We reviewed the laboratory fee schedules at one Medicare carrier for 1991 through 1993. We found that the Medicare fee schedules established by the carrier for payment of selected panel and profile laboratory tests were greater than the sum of the fee

schedule amounts for the component tests included in the panel and profile tests. Because of the error in setting Medicare payment allowances for these panel and profile tests, the carrier overpaid Medicare providers $12.7 million during the period January 1, 1991 through April 30, 1993.

The overpayments occurred with the Lipid profile test, the Thyroid panel test, the Hepatic Function panel, the Arthritis panel, the Prostatic panel, and the Macrocytic Anemia panel.

Effective July 28, 1993, the carrier revised its Medicare fee schedules to limit Medicare payment allowances for panel and profile tests to no more than the sum of Medicare payment allowances for the component tests. We recommended that the carrier (1) strengthen its policies and procedures to ensure that it complies with Medicare carrier guidelines; and (2) work with the Health Care Financing Administration to identify and collect the overpayments made to providers.

Reduce Payments for Clinical Laboratory Tests to the Lowest Level Available

Independent clinical laboratories have traditionally operated with two price lists: one that applies to insurance companies or other third party payers (including Medicare), and one that applies to physicians and other health providers. Independent laboratories depend on physicians to refer patients for testing, and physicians can negotiate prices that are reflective of a highly competitive market. These competitive market forces, however, are eroded when it comes to third party payers. Thus, the prices which are charged to insurance plans are usually substantially higher.

To counter this price differential, Medicare fee schedules went into effect July 1, 1984 for clinical tests reimbursed under Part B of the Medicare program. The fee schedule rates apply to tests performed on outpatients, whether done in physicians' offices,

independent clinical laboratories, or hospital laboratories. Tests done on hospital inpatients were not subject to fee schedules.

Our audit of Medicare reimbursement of clinical lab tests showed that the Medicare fee schedules are nearly double the actual amounts invoiced to physicians for the same tests. The difference was attributable to the way in which Medicare reimbursed for profiles, or batteries of tests, ordered as a group. While laboratories offered profiles to physicians at greatly reduced prices, Medicare usually paid for them at the fee schedule rates for the individual tests.

With the waiver of coinsurance on Medicare laboratory claims under the fee schedule, the program has every reason to expect to be charged competitive prices for laboratory tests. Instead, one of the laboratories we reviewed charged Medicare almost five times the prices it charged physicians for the same tests. Laboratory representatives told us they charged Medicare more because of unnecessary obstacles they faced in obtaining reimbursement from the program.

We estimated that if payments were comparable to what physicians were paying, Medicare would potentially save $426 million annually.

Chemistry Tests Performed on Automated Lab Equipment

We recently issued an early alert on the preliminary results of our nationwide review of chemistry tests performed on automated laboratory equipment. The objectives of our review were to (1) identify chemistry tests which should be paid as a panel (bundled), but are not included in the Physicians' Current Procedural Terminology (CPT) Manual's list of automated panel tests, and (2) quantify the savings to the Medicare program if these individual tests were reimbursed at panel rates.

Chemistry tests are commonly performed clinical laboratory services requested by physicians to diagnose and treat Medicare patients. The HCFA requires that any combination of chemistry panel tests currently listed in the CPT Manual which are ordered by a physician be bundled for payment purposes.

We found that the Medicare Part B program is paying single test payment rates for chemistry tests which are commonly performed on automated laboratory equipment. The CPT Manual lists chemistry tests which are normally performed on automated equipment (referred to as panel tests). The CPT Manual recognized 19 chemistry panel tests. In the industry, there have been numerous technological advances in the clinical laboratory field and an increased availability of automated testing equipment.

Our review identified additional chemistry tests which are performed on automated laboratory equipment and, in our opinion, should be included as panel tests and reimbursed at the lower panel test rates. We are continuing our review to quantify the potential savings to the Medicare program if these individual chemistry tests were reimbursed at panel test rates.

Based on the preliminary results of our review, we plan to recommend that HCFA update its list of chemistry panel tests, and periodically review and update the list to reflect changes and advances in laboratory technology and practices.

DEVELOPING ISSUES

Edits for Payment of Laboratory Panel Tests

This review will determine the adequacy of State agencies' prepayment edit safeguards for payment of laboratory panel tests. A panel test combines two or more laboratory tests under a

specific organ, disease or problem-oriented classification. State Agencies should have claims processing edits to prevent providers from (1) unbundling panel tests into their component tests, and (2) billing for panel tests and component tests on the same claim.

MANAGED CARE SERVICES

MANAGED CARE SERVICES

☞ 1993 TOTAL MEDICAID OUTLAYS -- NOT AVAILABLE

COMPLETED AUDITS

Adequacy of Financial Safeguards Over Medicaid Managed Care Plans

The Federal and State governments believe that managed care programs hold much promise in containing costs while providing greater access to, and improved quality of, care for the Medicaid program in both the short and long terms.

The OIG has recently issued a limited distribution report expressing its concern over the adequacy of safeguards in place at facilities with managed care plans to protect the interests of recipients and providers, as well as the interests of the State and Federal governments. We are particularly concerned with the issues of financial solvency, capitation rates, reinsurance requirements, and contracting standards for managed care plans. The OIG has finalized its in-depth review of one managed care plan. This review raised questions with respect to financial requirements for new managed care plans, the level of profit earned and its relationship to the setting of capitation rates, reinsurance requirements, and the reasonableness of related party transactions.

The OIG is continuing to explore these areas of concern. We will be conducting pilot projects to analyze the adequacy of the current requirements for financial solvency, the setting of capitation rates, reinsurance, and contracting standards for managed care plans.

DEVELOPING ISSUES

Family Rates for Medicaid HMO Enrollees

Commercial health insurance plans offer their enrollees family rates. Health Maintenance Organizations (HMOs), however, receive capitated payments for each enrolled Medicaid recipient. While this may be a marketing ploy for commercial HMOs, preliminary comparisons show that Medicaid may benefit if family rates were adopted. This issue will focus on determining if family rates would be beneficial and practical to compute.

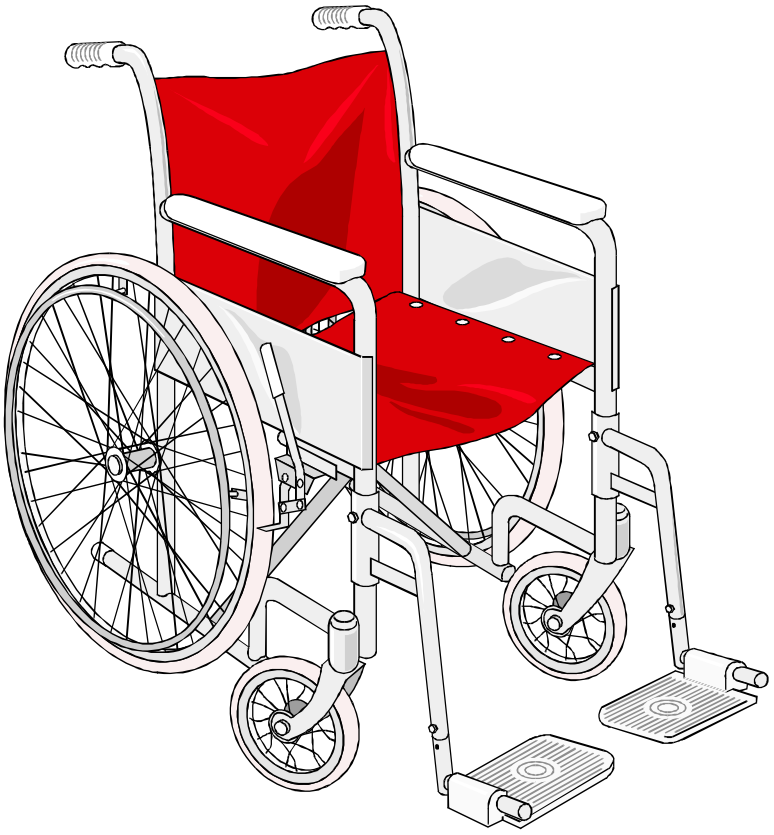
Medicaid Enrollment/Disenrollment Controls for Managed Care Plans

Medicaid Managed Care Plans receive a monthly capitation payment for each enrolled recipient. The accuracy and timeliness of enrollment/disenrollment actions have a significant impact on the monthly payment amounts. This issue will focus on the adequacy of States' controls to ensure that these actions are timely and accurate.

Medicaid Services Received While Enrolled in HMOs

This issue will focus on determining if State Medicaid agencies have adequate controls to identify Medicaid charges for dually eligible individuals which should have been paid by a Medicare HMO. Dually eligible individuals are issued both a State Medicaid card and, if enrolled in an HMO, a Medicare HMO card. Medicare pays the HMO a capitation rate which should cover most medical costs of the recipient. Should the recipient use the fee-for-service Medicaid card, charges for these services should be detected and denied.

DURABLE
MEDICAL EQUIPMENT



DURABLE MEDICAL EQUIPMENT

☞ 1993 TOTAL MEDICAID OUTLAYS -- NOT AVAILABLE

COMPLETED AUDITS

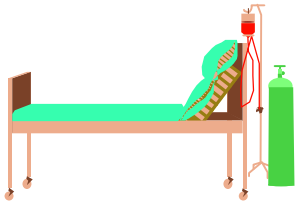
Excessive Payments for the Use of Hospital Beds in the Home

Medicare Part B allows reimbursement for a hospital bed used by a Medicare beneficiary in the home when the bed is prescribed by a physician. Reimbursement is based on monthly rental payments made according to a fee schedule established by the Omnibus Budget Reconciliation Act of 1987. Medicare payments are capped at 120 percent of the allowed fee schedule amount over a maximum period of 15 months.

Under the Medicare program, we found that the present payment system does not adequately reflect the 5-year useful life of hospital beds and the number of times that the bed can be rented. Adjusting the current method of reimbursement to reflect the useful life of hospital beds would result in a more equitable payment system and would produce significant savings.

Our audit work focused on the use of hospital beds by a random sample of Medicare beneficiaries in one State during 1989. The current Medicare reimbursement policy allows the supplier of a common type of hospital bed, a fully electric model, to recover the bed's wholesale cost in as little as 4 months. The maximum recovery period was 8 months for the most expensive bed identified.

The majority of rental periods in our sample were less than six months. Therefore, a supplier may recover the approximate wholesale cost of a bed with a single rental. With these short periods of actual use, suppliers are able to rent the same bed several times. The revenue available from the rental of a fully electric bed over its useful life could be $8,200 or more. This is a return of at least 4.5 times the amount of the current Medicare allowed retail price in that State and 7.5 times the wholesale cost of the bed.



From an analysis of our sample, we estimated that annual Medicare savings of $6.2 to $7.8 million and beneficiary savings of $1.6 to $2.0 million are available in that State, alone.

Identification of Unnecessary Reimbursement for Oxygen Concentrators

The Medicare program pays for medically necessary oxygen used by beneficiaries in their homes under the authority of section 1861(s)(6) of the Social Security Act. Coverage is limited to oxygen that is reasonable and medically necessary to carry out a home oxygen therapy program that necessitates the delivery of oxygen as prescribed by the patient's attending physician.

Coverage is provided for beneficiaries with significant hypoxemia (deficient oxygenation of the blood) in the chronic-stable state, hypoxia-related symptoms (deficiency of oxygen in the inspired air) or medical conditions that might be expected to improve

with oxygen therapy. Certain requirements must be met and other appropriate treatment measures must have been tried without success before these conditions will be covered.

The OIG audits of home oxygen therapy claims paid under Medicare by five carriers disclosed overpayments of about $31 million for a 1-year period. We found that over one-third of the beneficiaries whose claims were sampled during our audit either did not need oxygen or did not need oxygen to the extent billed.

The overpayments occurred primarily because weaknesses in the internal control systems did not hold the prescribing physician responsible and accountable for the documentation supporting the claims for home oxygen therapy. Most of the information required to document the medical necessity for home oxygen therapy was provided by the suppliers. As a result, in many instances, the physician's medical records did not contain data such as diagnosis, lab test results, or an oxygen prescription supporting the claim. Also, many physicians did not document the patient's condition or the patient's encounters that led to the prescribed use of oxygen.

Medicare Payments for Home Blood Glucose Monitors

Medicare payments for monitors, which are medical devices used by diabetics to measure blood sugar levels, were about $12 million in 1991. The objectives of our review were to (1) determine if Medicare claims for monitors were being reduced by manufacturers' rebates, and (2) evaluate the Medicare fee schedules for monitors.

Our review disclosed that excessive Medicare payments were made for monitors because claims were not adjusted to reflect manufacturers' rebates, resulting in Medicare overpayments. We also found that payment limits in fee schedules established for monitors were too high. Although monitors could be purchased for about $50, nationwide Medicare fee schedule limits ranged from $144 to $211.

We recommended that HCFA:

- work with carriers to identify rebate programs for possible violations of the anti-kickback statute,
- ensure that Medicare payments for monitors are net of any available rebate,
- continue efforts seeking legislation to allow carriers to apply inherent reasonableness to the fee schedule amounts, and
- require manufacturers to identify rebates paid to customers and recover any overpayments for claims filed for benefit payments.

DEVELOPING ISSUES

Reimbursement for Parenteral Nutrients

Parenteral nutrients are mixed by a pharmacist in a sterile environment and used by patients who are unable to maintain normal nutrition. This review would focus on determining the reasonableness of Medicaid reimbursement rates for pre-mixed parenteral nutrients. Our ongoing surveys have shown significant differences in reimbursement rates among payers. For this review, the Medicaid amount would be compared with

amounts reimbursed by other payers, such as Medicare, as well as the suppliers' cost for the nutrients.

Competitive Bid Contracts for Durable Medical Equipment

Medicaid programs have been authorized by law to use competitive bidding to provide durable medical products and services to recipients since 1984. Preliminary OIG research found that some Medicaid agencies have reported savings in their DME programs by utilizing competitive bid contracts.

Reimbursement for Infusion Pumps

A review has been proposed in the Medicare program to analyze reimbursement alternatives for infusion pumps. Estimates developed from a previous survey indicated that savings of over 82 percent of allowed charges could be achieved by modifying the reimbursement methodology. A similar review could be done in the Medicaid program that would include research on the useful life of the pumps, examination of the average Medicaid rental period, and review of actual cost data for various types of pumps on the market.

MEDICAL
TRANSPORTATION SERVICES

MEDICAL TRANSPORTATION SERVICES

☞ 1993 TOTAL MEDICAID OUTLAYS -- NOT AVAILABLE

COMPLETED AUDITS

Payments for Non-Emergency Advanced Life Support Ambulance Services

Part B of the Medicare provisions provides for coverage of ambulance service where the use of other methods of transportation is contraindicated by the individual's condition. The limitations for coverage of ambulance services include the requirement that the services be medically necessary, specifically, that other means of transportation would endanger the beneficiary's health. The HCFA allows separate reimbursement rates for basic-life-support (BLS) and advanced-life-support (ALS) ambulances.

Data obtained from HCFA shows that from 1986 to 1989, the number of trips by Medicare beneficiaries in ALS ambulances increased by 131 percent, while the number of trips in BLS ambulances increased by only 14 percent. Further, Medicare's allowed charges for ALS and BLS ambulances increased by $72 million from 1988 to 1989. Of this amount, $53 million or 73 percent was attributable to increased utilization of ALS ambulances. In our opinion, the increase in ALS utilization is caused, in large part, by policies which base payment on the mode of transportation rather than the medical necessity for the level of service.

An OIG review of 400 ALS ambulance claims in CY 1989 disclosed that 18 percent of the claims were for services not medically necessary at the ALS level of service and for which BLS services were available in the same city or town. We estimate that $15.95 million would be saved annually, $12.76 million by the Medicare Part B program and $3.19 million by beneficiaries, if payment were based on the medical need of the beneficiary.

We recommended that (1) payment for non-emergency ALS services be made only when that level of service is medically necessary and (2) controls be implemented to ensure that payment is based on the medical need of the beneficiary.

Opportunities for Greater Economy and Efficiency in Providing Transportation Services to Medicaid Recipients

We recently completed a review of medical transportation costs in one State to identify methods for controlling future costs. We concentrated solely on non-emergency trips identified by the State as commercial ambulatory services (CAS).

We found that this State could save at least $6 million (Federal share $3.8 million, State share $2.2 million) annually without reducing services offered to Medicaid recipients. The savings could be accomplished by the State (1) lowering its payment rates, (2) pursuing less expensive transportation alternatives, and (3) eliminating unallowable transportation claims.

For CAS trips that stay within county lines, about $2.1 million (Federal share $1.3 million, State share $0.8 million) per year could be saved by lowering the maximum payment levels to rates that approximate local community taxi fares with a maximum of $15.00 for a one-way trip. Additional cost savings could be obtained by (1) implementing a preferred pharmacy program that would maximize the use of free prescription drug delivery, and (2) utilizing local non-profit or volunteer

organizations willing to provide free or low-cost transportation services.

For CAS trips that go outside county lines, about $3.9 million (Federal share $2.5 million, State share $1.4 million) per year could be saved by lowering the maximum payment rate to $1.00 per mile with a maximum of $75.00 for a round trip. Some of the cost savings would be obtained by planning and coordinating high cost trips, such as those taken to dialysis treatment centers.

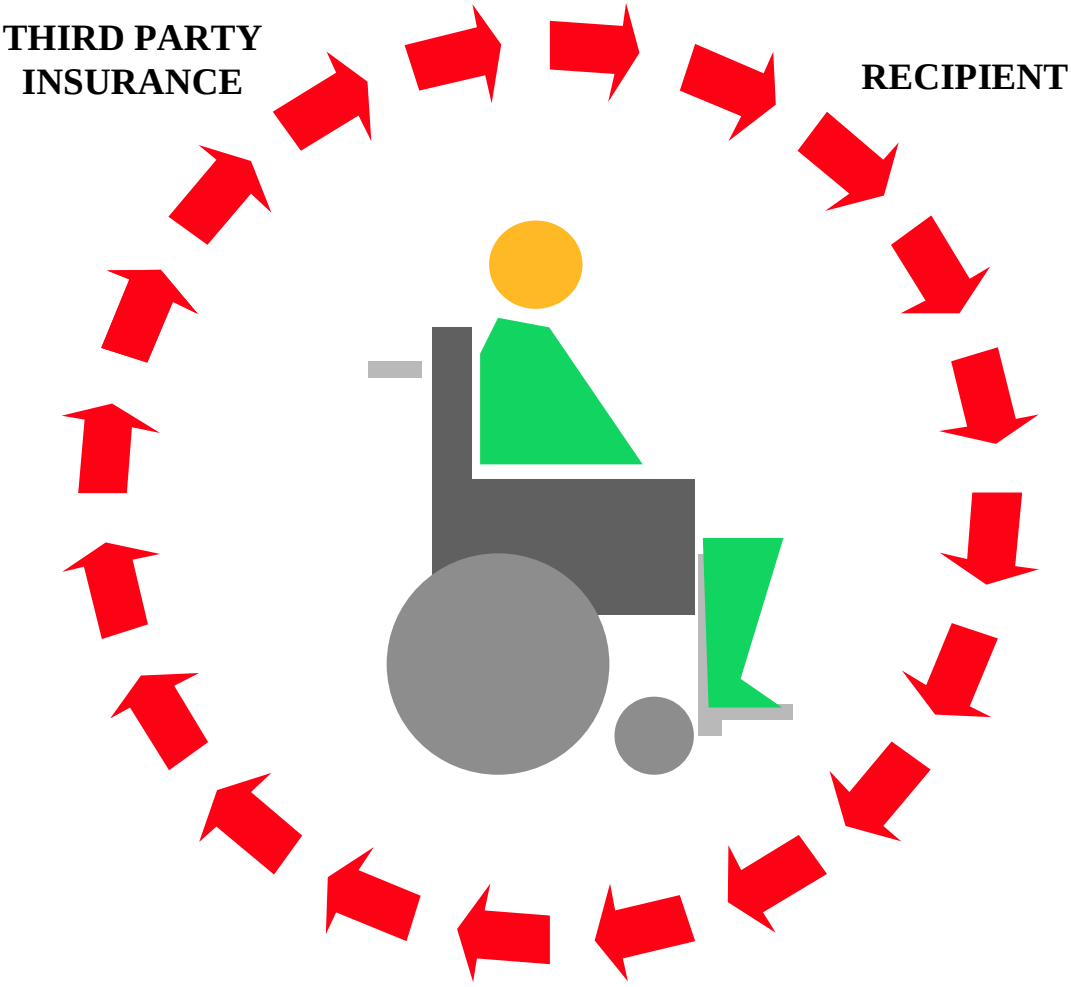
We also found that more than 12 percent of the paid transportation claims we examined were potentially unallowable costs because they could not be matched with a paid claim for a medical examination or treatment on the same date of service. We recommended that the State agency implement an annual computer edit of its paid claim database to identify all of these "unmatched" transportation claims for further research to determine allowability.

DEVELOPING ISSUES

Non-Emergency Medical Transportation

Medicaid expenditures for non-emergency medical transportation have risen dramatically over the last several years. This issue will focus on analyzing the controls implemented by State agencies to assure that payments for these services are necessary and reasonable. State Medicaid agencies are required by Federal regulation to assure that Medicaid recipients receive necessary services. The courts have interpreted this to mean that the States must provide for routine medical transportation services.

THIRD PARTY LIABILITY



THIRD PARTY LIABILITY

☞ 1992 TOTAL MEDICAID COST AVOIDANCES AND COLLECTIONS -- $14.7 BILLION

COMPLETED AUDITS

Identification and Collection of Third Party Liability Medicaid Cases

The Social Security Act requires that State Medicaid agencies take all reasonable measures to ascertain the legal liability of third parties to pay for services furnished to Medicaid recipients. Medicaid is intended to be the payer of last resort. Other available resources must be used before Medicaid pays the claim.

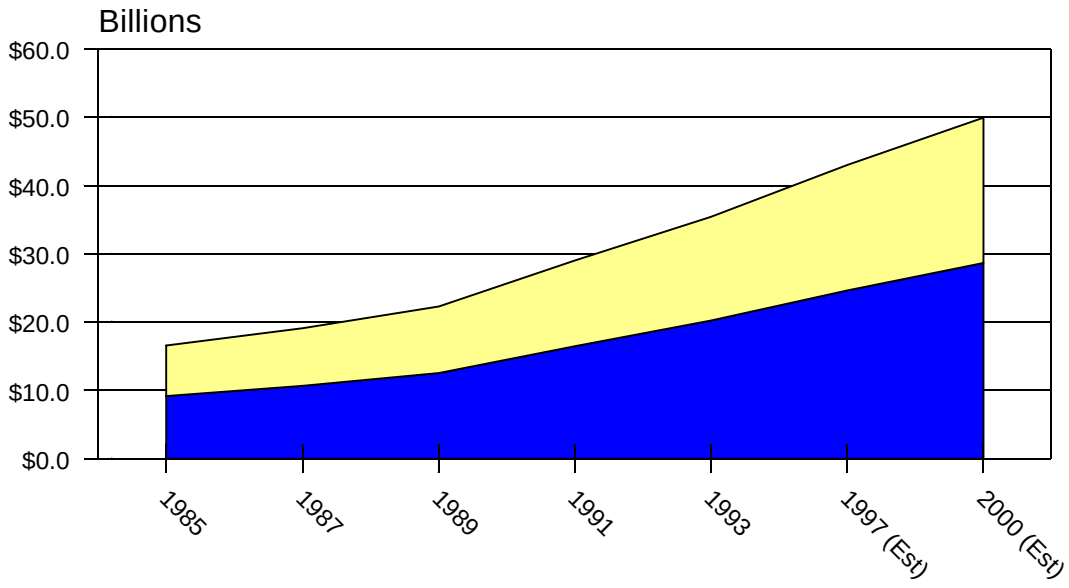
The HCFA provides general criteria and some monitoring for identifying third party liability (TPL) sources and sending out of initial bills by the States. However, our preliminary reviews indicate that HCFA does not provide State Medicaid agencies with guidance for recording and collecting TPL claims. Further, HCFA does not require State agencies to report on the status of outstanding TPL billings (receivables), or evaluate State agency efforts to collect TPL receivables owed to Medicaid.

The OIG has performed reviews of TPL systems in several States. One survey of six State agencies showed that five States do not have adequate systems to record and follow up on outstanding TPL billings. The receivables at these five State agencies were summarized to show how much was owed by

each TPL source. The State agencies could not readily determine how much they had billed each third party, how much of the billings were paid or rejected, or whether the third party was processing the bills in a timely manner.

In another State, our survey showed that although the State agency's TPL system identified liable third parties, it did not bill all third parties. In the case of one insurance company, billings were not made because the claims processing systems at the State Medicaid agency and the insurance company were not compatible. The State Medicaid agency had a large volume of hard copy claims, but the insurance company required that computer tape bills be sent for payment. While this caseload was at an impasse, both the State and Federal governments paid for Medicaid services that were the liability of a third party.

LONG TERM CARE



State	$7.4	$8.4	$9.7	$12.5	$15.2	$18.4	$21.2
Federal	$9.2	$10.7	$12.6	$16.5	$20.2	$24.6	$28.7
Total	$16.6	$19.1	$22.3	$29.0	$35.4	$43.0	$49.9

NOTE: Long Term Care is composed of skilled nursing facilities and all intermediate care facilities, including those for the mentally retarded.

LONG TERM CARE

☞ 1993 TOTAL MEDICAID OUTLAYS -- $35.4 BILLION

COMPLETED AUDITS

Adequacy of Controls Over Residents' Personal Funds Accounts

The OIG has issued several reports dealing with the personal funds accounts of long term care residents. The objectives of these reviews were to assure that long term care facilities had established and maintained adequate controls for safeguarding, managing and accounting for residents' personal funds accounts.

The reports noted, among other things, that the facilities reviewed (1) did not make timely refunds to former residents or their estates; (2) did not always notify residents when their account balance was within $200 of the Supplemental Security Income resource limit; (3) did not always obtain residents' authorization to manage their funds or charge their accounts; (4) permitted residents to overdraw their accounts; and (5) did not reconcile bank account balances to accounting records.

We recommended that the facilities establish policies and procedures to provide reasonable assurance of complying with Federal and State regulations governing residents' personal funds accounts. We also recommended that the facilities conduct a complete accounting of personal funds accounts to correct the deficiencies identified during our reviews.

DEVELOPING ISSUES

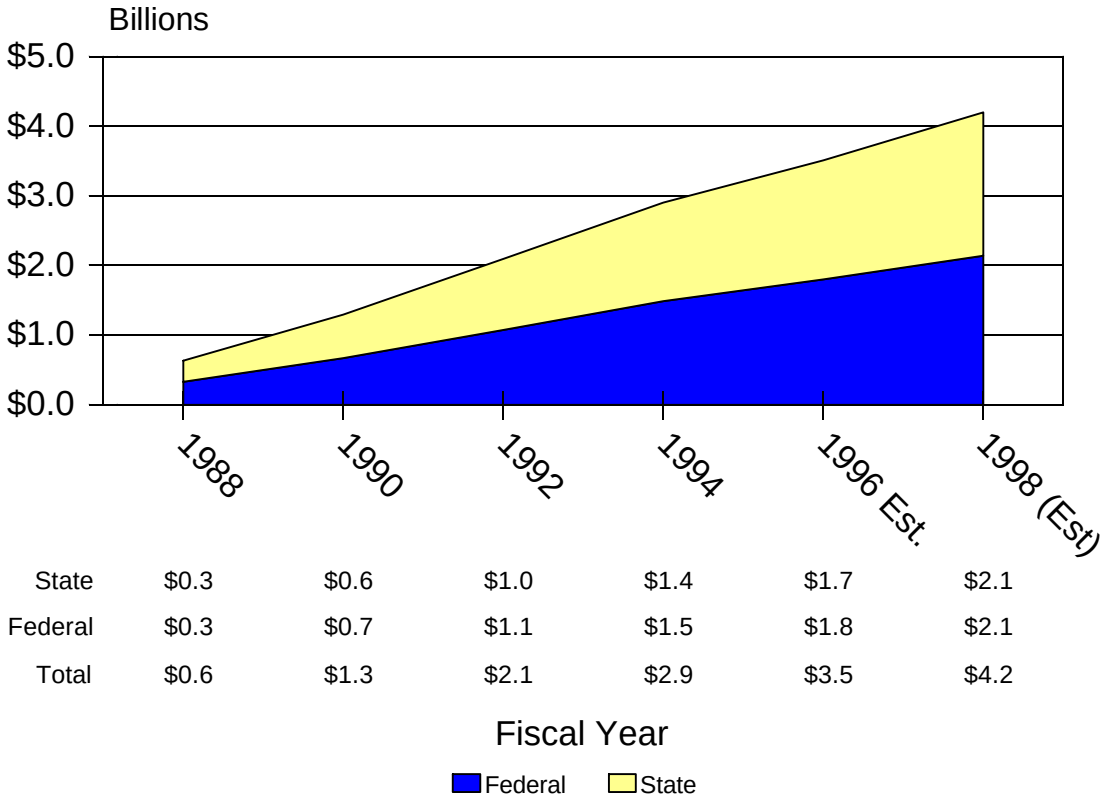
Overpayments to Intermediate Care Facilities for the Mentally Retarded

Many State Medicaid agencies reimburse intermediate care facilities for the mentally retarded (ICFs/MR) based on per diem rates established from the specific costs of individual providers. Retroactive adjustments may be made to the per diem rates based on required audits of costs to operate ICFs/MR. Downward adjustments to the per diem rates could result in substantial overpayments to ICFs/MR. This issue would focus on the adequacy of State agency procedures for adjusting per diem rates and identifying and collecting any resulting overpayments made to ICFs/MR.

Review of Skilled Nursing Facility Costs

The focus of this issue would be to determine the allowability and reasonableness of the three components of Skilled Nursing Facility costs. These components are routine costs (which are capped), capital-related costs and ancillary costs. Capital-related costs and ancillary costs, specifically therapy services (occupational, physical and speech), medical supplies and drugs, have increased greatly.

AIDS AND HIV INFECTION



State	$0.3	$0.6	$1.0	$1.4	$1.7	$2.1
Federal	$0.3	$0.7	$1.1	$1.5	$1.8	$2.1
Total	$0.6	$1.3	$2.1	$2.9	$3.5	$4.2

NOTE: All numbers above provided by HCFA's Office of the Actuary. Data systems currently available do not permit explicit identification of persons with AIDS or their associated medical care costs.

AIDS AND HIV INFECTION

☞ 1993 TOTAL MEDICAID OUTLAYS -- $2.5 BILLION

The delivery of needed medical services to AIDS patients is a growing concern of our country. We are in the process of identifying specific issues to review in this growing expenditure area. We welcome any input State Auditors or other State officials would like to provide.

DEVELOPING ISSUES

Financing Health Care for People With AIDS and HIV Infection

In Fiscal Year 1993, combined Federal and State Medicaid expenditures for AIDS-related care were approximately $2.5 billion ($1.3 billion in Federal funds and $1.2 billion in State funds). The cost of AIDS-related health care services under Medicaid represented about 1.5 percent of Medicaid's total payments. These outlays are projected to reach $3.84 billion per year by 1997.

The HCFA estimates that, nationally, Medicaid serves at least 40 percent of all people with AIDS and up to 90 percent of all children with AIDS. In some geographic areas, especially those with large numbers of intravenous drug users, the percentage of people served by Medicaid rises to as high as 65 to 75 percent. Medicaid pays on the average about 25 percent

of all direct medical expenditures of people with AIDS. The State Medicaid agencies constitute the largest avenues through which HCFA finances AIDS and HIV-related care. The States have broad flexibility to use Medicaid to meet local needs and assure broad access to care. States are encouraged to provide optional services that are often particularly appropriate to people with AIDS or HIV infection, such as targeted case management and hospice services.

Case management services allow States to extend services to targeted groups of eligible people to help them gain access to needed medical, social, educational, and other services. As of September 1992, 42 States offered targeted case management services with 8 of those States specifically targeting people with AIDS or HIV infection.

Hospice programs provide comprehensive care to terminally ill patients and include extensive coverage of home care, physician services, nursing care, medical appliances and supplies, home health aide and homemaker services, therapies, medical social services, and counseling. Currently, 35 States offer hospice care services under the Medicaid program.