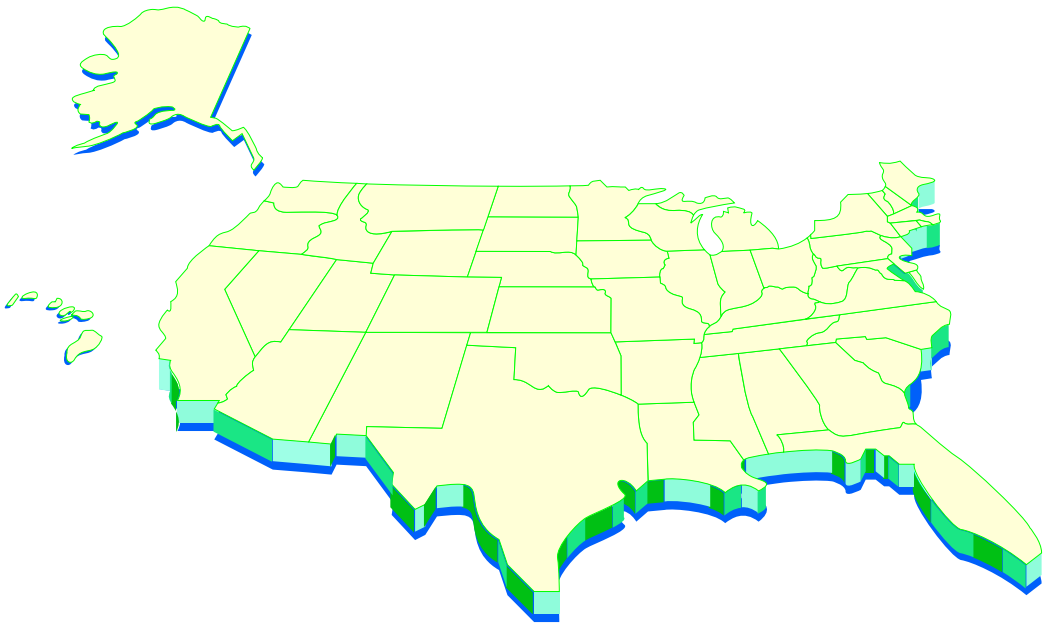
Partnerships Work and Deliver Results

A Summary of Federal/State Joint Audit Initiatives



JUNE GIBBS BROWN
Inspector General

July 1996

MESSAGE FROM THE INSPECTOR GENERAL

About 2 years ago, we began an initiative to work more closely with State Auditors in reviewing the Medicaid program. The Office of Inspector General (OIG) created the Partnership Plan (see back pocket for a disk copy of our original Partnership Plan and this document) in an effort to provide broader coverage of the Medicaid program by partnering with State Auditors to conduct joint reviews. We believed that this Partnership approach would be a more effective and efficient use of scarce audit resources by both the Federal and State audit sectors. We provided the Plan to all State Governors and State Auditors and they were invited to participate in this rather ambitious undertaking. This is an appropriate time, through this booklet, to:

- reflect back on the accomplishments of the Plan; and
- generate interest in developing additional partnerships.

I am pleased to report that the implementation of the Plan has been a resounding success. State Auditors have shown a great interest creating partnerships and we are getting an increasing number of inquiries on other potential joint projects. Active partnerships have been developed with 15 State Auditors on such diverse issues as Medicaid prescription drugs, clinical laboratory services, and durable medical equipment. Twenty State Auditor partnership reports have been issued, to date, with a financial impact of over $100 million on both Federal and State Government funds.

The concept was expanded beyond developing partnerships with State Auditors, and work has been accomplished with 11 State Medicaid program agencies on a national review of pharmacy acquisition costs for Medicaid drugs. We have also begun work with two State internal audit groups on additional Medicaid issues.

The OIG remains committed to full implementation of the Partnership Plan, and would very much like to perform joint audit work with every State. We stand ready to provide any technical assistance, share our audit guides, and/or provide computer applications assistance. This booklet provides detailed information on the projects accomplished as part of our initial Partnership Plan activities. As a result of our continuing work on health care delivery issues and our interaction with State Auditors, we are providing information on new or developing issues which we hope will lead to additional partnership efforts.

Those interested in participating in a joint effort with our office are invited to contact any of the individuals noted on page 10 of this document. Copies of this booklet are being provided to 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 Accomplishments

Partnerships Work and Deliver Results

OVERVIEW

Our original “Partnership Plan," which we last published in 1994, has met with overwhelming success. The theme of that Plan was for the Office of Inspector General (OIG) to work together with State Auditors to enhance audit coverage over the Medicaid program. In 2 short years, our Plan has evolved from a proposed idea to the actual development of productive partnerships with State Auditors to confront the upward spiraling of Medicaid costs. The concept of working together is not new, but the level of enthusiasm exhibited by our partners is a testament to their commitment to making government work better. Because of the widespread interest in our Plan, it has also evolved beyond working only with State Auditors to working with other State groups including Departmental Internal Auditors, Departmental Inspectors General, Medicaid Agencies, and the Health Care Financing Administration’s (HCFA) financial managers.

Active partnerships have been developed with 15 State Auditors, 11 State Medicaid Agencies, and 2 State internal audit groups involving:

- program issues related to Medicaid outpatient prescription drugs,
- unbundling of clinical laboratory services,
- outpatient non-physician services already included as an inpatient charge,
- excessive costs related to hospitals transfers,
- excessive payments for durable medical equipment (DME), and
- acquisition costs for Medicaid drugs.

In addition HCFA, in partnership with OIG, has mandated that its Regional Offices conduct reviews of Medicaid drug rebate issues during State site visits. State Auditors have also included Partnership issues as part of their Statewide Single Audits. And one State has gone far beyond what we envisioned in the Plan by mandating through legislation, that the Legislative Auditor participate with the OIG in a program of joint audits for all projects identified in the Partnership Plan.

We are continuing to develop additional partnerships with State Auditors and State Departmental groups through direct contacts, Intergovernmental Audit Forum meetings, the Association of Government Accountants, and other professional organizational meetings. We are also striving, through our normal audit work, to identify and develop new issues for joint projects for our current State partners as we continue to look for issues that will aid in ferreting out fraud, waste, and abuse in the Medicaid program.

With the increasing concern over fraud and abuse in the health care field, we plan to develop new Partnerships with the 42 State Medicaid Fraud Control Units (MFCU). The objective of the legislation which created the MFCUs was "to strengthen the capability of the government to detect, prosecute, and punish fraudulent activities under the Medicare and Medicaid programs...." We believe that forming Partnerships with MFCUs would enhance both of our current efforts by expanding coverage to areas which are not now being reviewed.

THE BEGINNINGS OF THE PARTNERSHIP PLAN

In keeping with the National Performance Review and the Department of Health & Human Services goals to strengthen partnerships with its customers, the OIG developed and implemented a Partnership Plan designed to provide (1) broader coverage of the Medicaid program; and (2) a more effective, efficient, and economical use of audit resources by working together with State Auditors. In that Plan, we discussed previous OIG audit work on Medicaid issues and Medicare audit issues which we believed could be applied to the Medicaid program. We distributed the Plan to the State Governors and State Auditors and invited them to join with us in working together. Copies of the “Partnership Plan” are available in hardcopy, computer diskette, or on the Internet at the IGNET website **(http://www.sbaonline.sba.gov/ignet/internal/hhs/hhs.html)**.

The response to our Plan has exceeded our expectations because the resulting joint projects have had mutual benefits to all of the participating Partners. Our joint projects have resulted in reports which have identified areas where improvements in program operations could be achieved, unallowable program expenditures could be recovered, and future cost savings could be recognized. These reported program improvements benefit both the States and the Federal Government. This has been one of the most attractive aspects of the Plan. The Plan has also been successful because of the flexibility inherent in our Partnership concept; the level of involvement of each Partner can vary depending upon specific situations and available resources. The OIG remains committed to the Partnership Plan and our Partners who have ventured with us into the new beginnings of partnering in the 90's. We will continue to provide technical and computer support as well as other resources to assist our partners.

Issued reports that have resulted from joint projects with the OIG, State Auditors, and/or Departmental Internal Audit groups have been transmitted to HCFA for their use in determining whether national directives are needed to address the specific issues. Examples of some specific projects are discussed below.

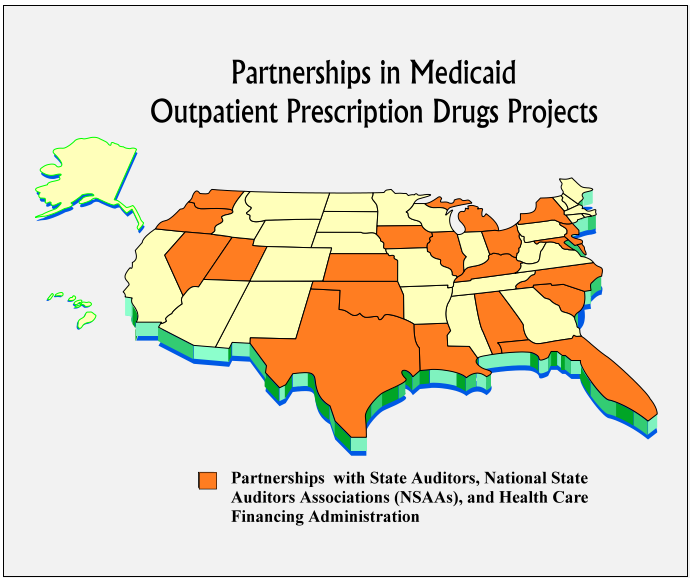
POPULAR PROJECTS

Medicaid Outpatient Prescription Drugs

One of the most successful and popular projects performed by the State Auditors under our partnerships have been audits of the Medicaid prescription drug program. Medicaid regulations provide for the reimbursement of outpatient prescription drugs. The Omnibus Budget Reconciliation Act of 1990 created the Medicaid drug rebate program which provided for participating drug manufacturers to pay rebates back to the States.

Over the past several years, the OIG has been actively involved in reviewing many aspects of the prescription drug program such as the use of ulcer treatment drugs, generic drugs, and accountability and control over drug rebates. Because of this experience, the OIG has been able to provide States with many potential drug areas to review. Five States, North Carolina, Texas, Louisiana, Washington, and Montana, have conducted reviews of the effectiveness of the collection of the rebates due from drug manufacturers.

The varying levels of involvement by the OIG and the States in these drug reviews display the flexibility available under the Plan. For example, in North Carolina the OIG provided staff to work with the State Auditor on the review. In this same State, the Inspector General participated in a publicized joint signing of the report with the Governor, Lieutenant Governor, and State Auditor of North Carolina in attendance. The Inspector General also appeared on television with the State Auditor, and met with local reporters in a question/answer program to promote the Partnership efforts and the results of the audit. In other States, we provided technical assistance to the State Auditors in the form of audit guides and training for those staff who actually conducted the field work and reporting. The financial impact related to these drug projects amounted to about $13.6 million. Also, the National State Auditors Association (NSAA) issued a consolidated report in 1995 on the results of eight State Auditor reviews of the Medicaid Prescription Drug Program. For that review, we also provided audit guides and training to the participating States. Individual reports were issued to Maryland, Delaware, Iowa, Michigan, Missouri, Ohio, Texas, and Utah. The financial impact of the NSAA audits amounted to $73.5 million.

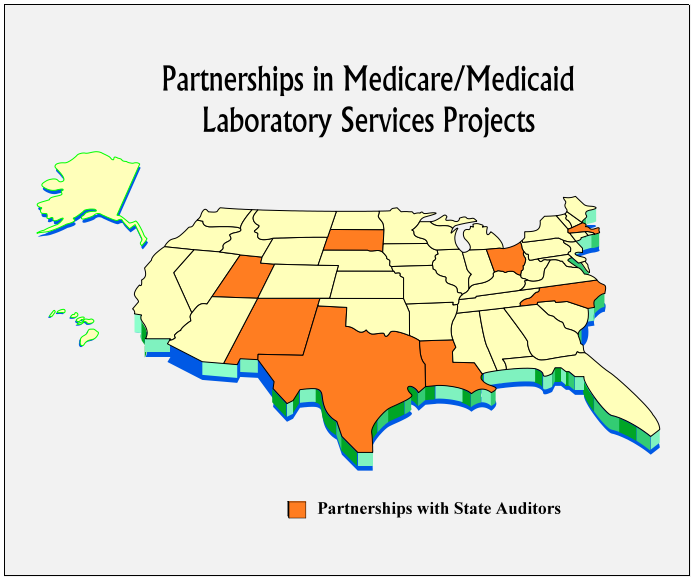


The HCFA also conducted financial management reviews through its regional financial managers. These reviews were performed through partnership with the OIG with kickoff and planning conferences held in Kansas City for pilot reviews that were performed in Missouri and Kansas. Fourteen reviews have been completed in New York, District of Columbia, Illinois, Ohio, Oklahoma, Missouri, Nevada, Oregon, Washington, Iowa, South Carolina, Florida, Kentucky, and Alabama with monetary adjustments totaling $4.5 million.

Laboratory Services

Five states, Ohio, North Carolina, Texas, Massachusetts, and Louisiana have completed audits of clinical laboratory services and have identified about $12 million in unallowable charges for unbundled and duplicated lab services. Ohio, Texas, and Massachusetts

conducted these audits using their own staffs with technical support and computer assistance supplied by the OIG. The North Carolina review was conducted by the OIG with staff support supplied by the State Auditor. In Louisiana, computer applications and staff support was supplied by the OIG and the State Auditor was the lead on the review.



Within broad Federal guidelines, States design and administer the Medicaid program under the general oversight of HCFA. Clinical laboratory services, covered under the Medicaid program, include chemistry, hematology, and urinalysis tests. Laboratory tests are performed on a patient's specimen to help physicians diagnose and treat ailments. Testing may be performed in a physician's office, a hospital laboratory, or by an independent laboratory.

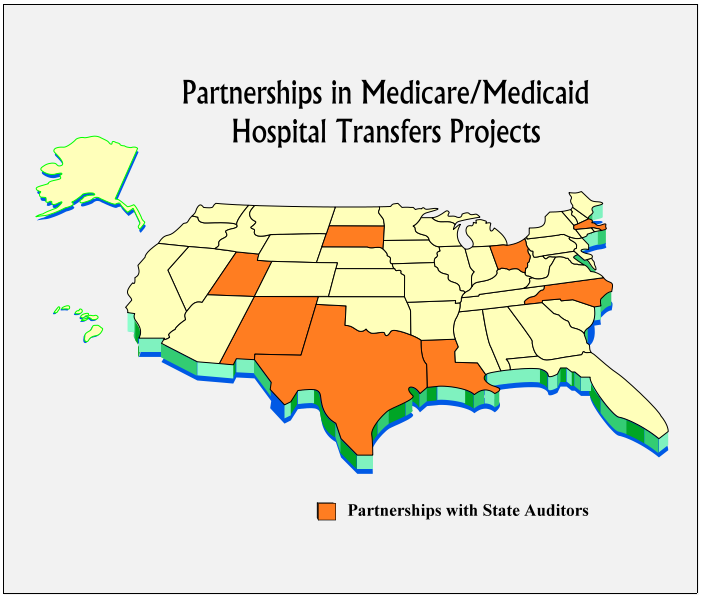
Federal matching funds are not available where a State pays more for outpatient clinical laboratory tests than the amount Medicare recognizes for the same tests. The objective of these reviews was to determine the adequacy of procedures and controls over the processing of Medicaid payments to providers for clinical laboratory tests. These audits are finding that adequate edits are not in place to prevent the payment of unbundled or duplicated claims for certain laboratory services.

Two States, Utah and New Mexico, are beginning Partnership efforts in laboratory services. The OIG and State staffs are working together to create computer applications to identify potential unbundling of lab claims in these reviews. What makes these reviews attractive to our partners is the use of computer applications that can be developed and applied to identify potential overpayments to providers. Once these potential overpayments have been identified, the validation of the results does not require use of a lot of staff resources to complete the project.

Hospital Transfers

The Texas State Auditor Office (TSAO) conducted a review of overpayments to prospective payment system (PPS) hospitals for improper coding for hospital transfers. The TSAO identified $736,000 in unallowable payments to hospitals. The TSAO found that the State could realize annual potential savings of approximately $290,000 by establishing computer edit checks to detect patient transfers that were coded as discharges. The South Dakota Legislative Auditor (SDLA) also conducted a review of hospital transfers. The TSAO and the SDLA conducted these reviews using their own staffs. The OIG provided technical assistance to these States during the reviews.

Under Medicare, a PPS hospital should code an inpatient claim as a transfer rather than discharge when the patient is readmitted to a second receiving PPS hospital on the same day. The first PPS hospital should receive a per diem payment rather than the full inpatient Diagnosis Related Group (DRG) payment. The receiving hospital which normally would provide a wider range of services should receive the full DRG payment. Some States' Medicaid programs have similar requirements for inpatient hospital stays. The TSAO and the SDLA reviews focused on transfers that were improperly reported as a discharge and resulted in both hospitals receiving the full DRG payment when only the receiving hospital should have received the full payment.

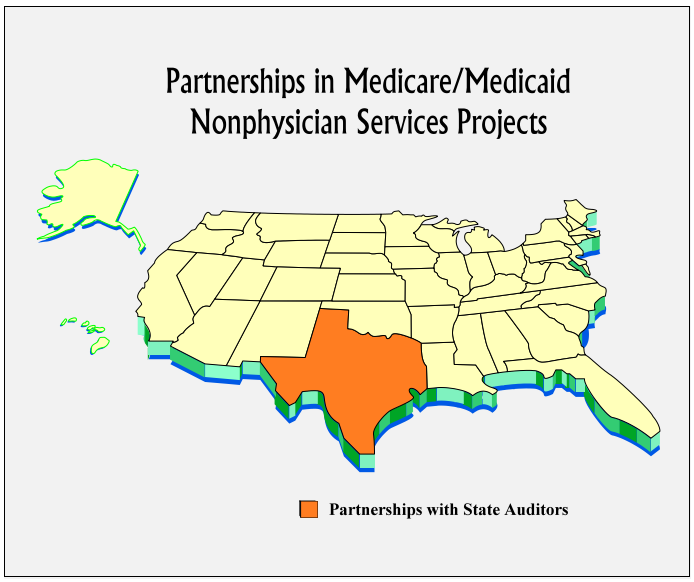


The OIG met with the TSAO staff and provided technical assistance at the beginning of the audit and met with the TSAO staff several times during the audit to answer questions concerning technical issues.

Nonphysician Services

The TSAO also performed an audit of billings for nonphysician outpatient services. The TSAO found that the State could save about $824,000 annually if the payment window was expanded to three days as currently required by Medicare.

Under the Medicare PPS, costs for certain nonphysician outpatient preadmission services are already included in the inpatient DRG payment for a hospital stay. Medicare requires that hospitals should not bill separately for these services which were performed 72 hours prior to inpatient admission. State Medicaid programs which have DRGs which also include the cost for such services in their hospital DRG payments could benefit by following the Medicare requirements. This is the approach the TSAO took in its review of this issue and found that significant savings could be achieved by following the Medicare requirements.

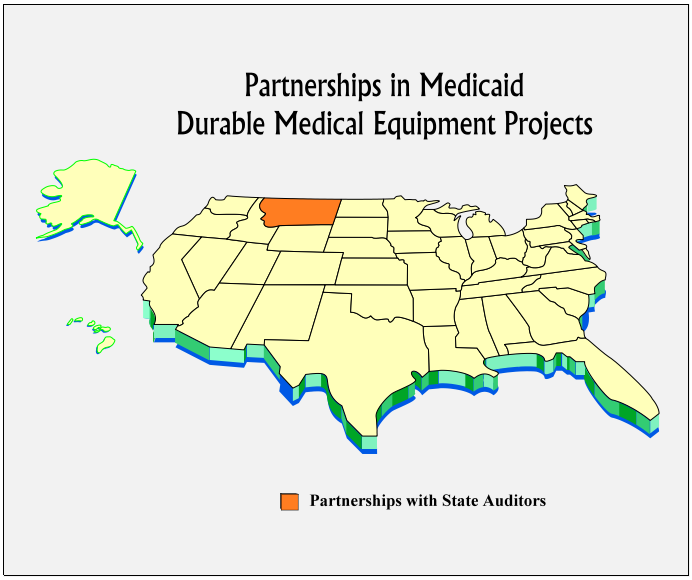


This audit was performed in conjunction with the Hospital Transfers audit described above. Again, the OIG met with the TSAO and provided technical assistance and conducted subsequent meetings to discuss issues that developed during the audit.

Durable Medical Equipment

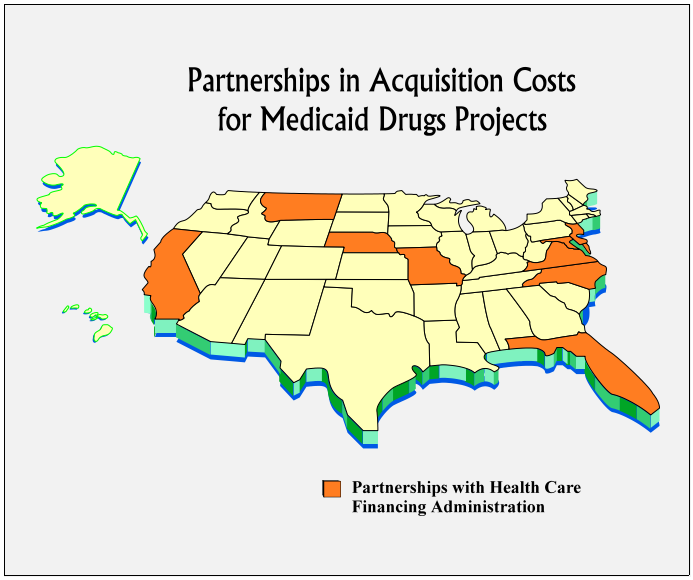
The Montana Legislative Auditor (MLA) conducted an audit of Medicaid expenditures for DME and supplies and found that the State could save between $336,000 and $504,000 annually by utilizing competitively bid term contracts in obtaining oxygen concentrators. Also, an additional annual savings of over $24,000 could be realized if the State contract were modified or expanded to include Medicaid items. The MLA also identified questionable charges of $134,000 to the Medicaid program. The MLA used its own staff on this review with the OIG providing technical assistance.

Medicaid programs have been authorized by law to use competitive bidding to provide DME to recipients since 1984. In the Partnership Plan, we identified competitive bid contracts for DME as a developing area since some Medicaid agencies had reported savings by using competitive bid contracts. The MLA took this issue and determined that significant savings could be achieved by using such contracts.



Acquisition Costs for Medicaid Drugs

The OIG completed field work and issued reports on a nationwide review of pharmacy acquisition costs for drugs reimbursed under the Medicaid prescription drug program in 11 States. Although not a State Auditor partnership, this review was conducted at the request of HCFA and was completed with the assistance and cooperation of the 11 State Medicaid Agencies as well as HCFA. From the planning of the review, during the review, up through the drafting of the reports, the OIG, HCFA and State Agency officials met, discussed and resolved potential problems. The results of this review, which could have a major impact on Medicaid drug reimbursement, would not have been possible without the forming of a partnership among all parties.



Medicaid regulations provide for the reimbursement of drugs in two methods. If a drug is a multiple source (generic) drug, then reimbursement is based on the lower of the pharmacist's usual and customary charge to the general public or a Federal upper limit (FUL) amount plus a dispensing fee. The FUL amounts are established by HCFA. If a drug is a single source (brand name) drug, a generic drug for which an upper limit amount has not been established, then the reimbursement is the lower of the pharmacist's usual and customary charge to the general public or the estimated acquisition cost plus a reasonable dispensing fee. State agencies are responsible for determining the estimated acquisition cost and the dispensing fee.

Meetings were held with HCFA and the 11 States: California, Delaware, District of Columbia, Florida, Maryland, Missouri, Montana, Nebraska, New Jersey, North Carolina, and Virginia. The audit results showed that nationally average wholesale prices exceeded invoice prices for brand name drugs by 18.3 percent and generic drugs by 42.5 percent. Calculations were made for each of the 11 States and they will evaluate the use of this information in studying its pharmacy reimbursement methodology.

Partnership Coordination--OIG Contact

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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ASSISTANT INSPECTOR GENERAL FOR HEALTH CARE FINANCING AUDITS
N2 25-26 NORTH BUILDING
7500 SECURITY BOULEVARD
BALTIMORE, MARYLAND 21244-1850
(410) 786-7104

Regional contacts are:

BOSTON (617) 565-2684	Richard Ogden, Regional Inspector General for Audit Services JFK Federal Building, Room 2425 Boston, MA 02203
NEW YORK (212) 264-4620	John Tournour, Regional Inspector General for Audit Services 26 Federal Plaza, Room 3900A New York, NY 10278
PHILADELPHIA (215) 596-6743	Thomas J. Robertson, Regional Inspector General for Audit Services 3535 Market Street, Room 4300 Philadelphia, PA 19101
ATLANTA (404) 331-2446	Charles J. Curtis, Regional Inspector General for Audit Services P. O. Box 2047 Atlanta, GA 30301
CHICAGO (312) 353-2618	Paul Swanson, Regional Inspector General for Audit Services 105 West Adams, 23rd Floor Chicago, IL 60603
DALLAS (214) 767-8415	Donald L. Dille, Regional Inspector General for Audit Services 1100 Commerce St., RM 4A-5 Dallas, TX 75242
KANSAS CITY (816) 426-3591	Barbara Bennett, Regional Inspector General for Audit Services 601 E. 12th Street, Room 284A, Kansas City, MO 64106
SAN FRANCISCO (415) 437-8360	Lawrence Frelot, Regional Inspector General for Audit Services 50 United Nations Plaza, Room 171, San Francisco, CA 94102

Section II

New Potential Audits and Developing Issues

PREFACE

Section II is a compilation of either new potential audits or developing issues which we have identified from our normal workplan activities. A compilation of past OIG Medicare and Medicaid reviews and other issues that are suggestions for joint audits are contained in the Partnership Plan booklet. Computer diskettes are included in the back of this booklet for the Partnership Plan and this publication.

We are continuing to look for issues to add to the proposed joint projects. 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 OIG will provide technical assistance, audit guides and computer programs as necessary. The type 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:

Ben Jackson, Audit Manager
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N2 25-26 North Building.
7500 Security Boulevard
Baltimore, Maryland 21244-1850
(410) 786-7113

OR

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1100 Commerce Street, Room 4A5
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NARRATIVE DESCRIPTION OF POTENTIAL AUDITS AND DEVELOPING ISSUE AREAS

MEDICAID DENIALS OF INPATIENT ACUTE HOSPITAL STAYS

States enter into contracts with Peer Review Organizations (PROs) to perform peer reviews of inpatient hospital stays to determine whether the services were appropriate and met professional recognized standards. The PRO has the authority to deny claims when their examination of the medical records determines that the claimed services were inappropriate or failed to meet professional standards. These denied claims are reported back to the State Medicaid Agency for recovery. Reviews have shown that these denied claims are not being recovered because follow-up procedures to timely review, evaluate, and clear these denied claims are not present.

PHYSICIAN CLINICAL BILLING PRACTICES

Medicare regulations contain certain requirements that govern reimbursement for services provided to patients by supervising physicians in a teaching setting. These requirements are necessary to avoid duplicate payments for a physician's service through Part A and Part B of Medicare. A teaching setting exists in any facility having residents on its staff.

Within the confines of this teaching setting, coverage of Medicare Part B is limited to those services actually provided by a physician, or under his/her direct and personal supervision, provided these services are documented to indicate his/her involvement. No Part B benefits may be paid for those services which are strictly supervisory in nature. The term "Physician" does not include residents; therefore, no payment may be made for his/her services related to the resident's training program.

The objective of the review is to determine whether Medicaid reimbursements for professional services provided by clinical practice providers of the hospital to Medicaid beneficiaries during an inpatient admission were reasonable, allowable, and documented.

Results from Medicare audits showed:

- Billing by faculty physicians for services actually performed by resident physicians in training. Under the Medicare program, the Government already pays for a substantial portion of the residents' training and salaries, and their services cannot be billed to the Medicare program on a fee-for-service basis. Certain physicians' bills represented that they had personally provided the service done by the residents.

- Billing by faculty physicians for in-patient consultations at the highest levels of the coding system, without reference to the services actually performed.

- Submitting many different types of bills with inadequate documentation in the medical record to support the claim for services.

MEDICAL EQUIPMENT, SUPPLIES AND RELATED ITEMS

Durable medical equipment (DME) are items that can withstand repeated use and include oxygen equipment, hospital beds, wheelchairs, and other equipment that physicians prescribe for home use. Prosthetics and orthotics are devices that replace all or part of a body organ and include leg, arm, back, and neck braces as well as artificial legs, arms, and eyes. In addition, Medicare classifies enteral and parenteral nutrition therapy under the prosthetic device benefit. Medical supplies include catheter supplies, ostomy supplies, incontinence supplies, and wound care supplies. For certain pieces of equipment and supplies, suppliers submit claims along with authorization documents known as certificates of medical necessity prepared by a physician.

In Fiscal Year 1994, Medicaid expenditures for DME totaled about $400 million. Under Medicare, we have issued numerous reports on problems with this category of service and undertaken a large number of investigations. Some of the problems we have seen include:

- Filing claims for equipment that was never delivered.

- Billing for high cost equipment when lesser cost equipment was actually provided (upcoding).

- Billing for the component parts of a piece of equipment instead of the entire unit (unbundling).

- Delivering equipment that has no medical benefit or delivering medical equipment to beneficiaries who do not need it.

- Having Medicare reimbursement rates that are clearly excessive when compared to payments made by other payers or compared to the wholesale costs, or market discounts.

We have aggressively pursued those who have defrauded our programs in this area. Between 1990 and 1995, our investigations led to 145 successful criminal prosecutions of DME suppliers or their employees. During the same period, we imposed 35 civil money penalties (totalling more than $43 million) and excluded 284 DME companies or their employees from the Medicare and Medicaid programs. The following is a brief description of some of the work that we have done on DME over the past few years.

Enteral Nutrition Therapy -- We found that Medicare payments for enteral nutrients are excessive because nursing homes and even other third party payers are purchasing enteral nutrients at significantly lower prices than current Medicare levels.

Nebulizer Drugs -- We found that Medicare and its beneficiaries could have saved $37 million if they had used the payment methodology used by Medicaid for nebulizer drugs.

Wound Care Supplies -- We found that questionable payments of wound care supplies may have accounted for as much as two-thirds of the $98 million Medicare allowed for these items from June 1994 through February 1995.

Incontinence Supplies -- We found that questionable billing practices may account for almost half of the $230 million allowed for incontinence supplies in 1993. We have convictions for "carrier shopping" and billing for incontinence supplies that were never delivered.

Lymphedema Pumps -- Several of our investigations have shown that manufacturers and providers misrepresent the type of pump issued to Medicare beneficiaries in order to obtain significantly more reimbursement.

Oxygen Systems -- We found that Medicare, on the average, allowed 174 percent more than the Department of Veterans Affairs reimburses for oxygen concentrators. We also found significant variation in the services provided to beneficiaries associated with oxygen concentrators.

Orthotic Body Jackets -- We reported that 95 percent of claims paid by Medicare ($14 million in 1992) were for non-legitimate devices. We have also obtained convictions of entities that billed Medicare for body jackets when they really provided seat pads.

Intraocular Lenses -- We found that ambulatory surgical centers were paid about $126 for intraocular lenses while the Medicare reimbursement was $200.

Total Parenteral Nutrition -- We determined that Medicare overpaid $69 million for total parenteral nutrition in 1991 (43 percent of total expenditures).

Hospital Beds -- We found that while an electric hospital bed can be acquired for about $1000, Medicare payments total $7000 over the useful life of the bed.

Home Blood Glucose Monitors -- We found that while monitors could be purchased for $50 at a drug or grocery store, Medicare fee schedules ranged from $144 to $211.

Seat-Lift Chairs -- Our analysis indicated that aggressive national marketing by suppliers had resulted in many beneficiaries initiating the request for the chairs.

MEDICAID PRESCRIPTION DRUGS
AVERAGE WHOLESALE PRICE

Medicaid regulations provide for the reimbursement of drugs in two methods. If the drug is a multiple source (generic) drug, then reimbursement is based on an upper limit amount plus a dispensing fee. The upper limit amounts are established by HCFA and the State agencies determine the dispensing fee amount. If a drug is a single source (brand name) drug, or a generic drug for which an upper limit amount has not been established, then the reimbursement is the lower of the pharmacist's usual and customary charge to the general public or the estimated acquisition cost (EAC) plus a reasonable dispensing fee. The State agencies are responsible for determining the EAC and the dispensing fee.

Prior to 1984 most states used 100 percent of the average wholesale price (AWP) as their acquisition cost for reimbursement purposes. Today, most States use AWP for a drug less some percentage as their EAC. The AWP is the price assigned to the drug by its manufacturer and is listed in either the **Red Book** or **Blue Book.**

In November of 1990, the Omnibus Budget Reconciliation Act of 1990 was passed and it placed a 4-year moratorium on changes to States' reimbursement policies. The moratorium expired on December 31, 1994 and many States have expressed interest in obtaining studies and audits of the difference between AWP and EAC for purposes of studying the effect on their reimbursement methodologies.

We have completed audits in 11 States and plan to issue a report to HCFA projecting national results. Through statistical sampling, we obtained pricing information from 381 pharmacies in 11 States. We obtained 20,735 invoice prices for brand name drug products, and 10,337 invoice prices for generic drug products. The combined nationwide point estimate of the extent that AWP exceeded invoice prices was 18.3 percent for brand name drugs and 42.5 percent for generic drugs. The point estimates combine the results for four categories of pharmacies including rural-chain, rural-independent, urban-chain, and urban-independent.

States not included in our sample could benefit from conducting a similar review in their State to help address the difference between AWP and EAC and adjust their reimbursement methodology accordingly.

MEDICAID PRESCRIPTION DRUGS DISPENSING FEES

In the Medicaid Outpatient Prescription Drug program, participating pharmacies are reimbursed drug ingredient costs plus a dispensing fee for each prescription. Dispensing fees vary by State with some States having multiple fees. The payment of dispensing fees by private insurers and health maintenance organizations is also a common industry practice. We are planning to conduct an audit to compare the Medicaid fees for drug dispensing to the fees paid by other insurers to determine whether Medicaid is subsidizing other insurers. Several State Medicaid Pharmacy Administrators have expressed concern that their dispensing fees are higher than those paid by other insurers such as managed care providers, which would amount to a Medicaid subsidy of other insurers. If our audit shows that the Medicaid fees are, in fact higher, then States could be encouraged to consider adjustment of the fees to a level of the predominant insurer.

HOSPICE CARE - Eligibility

The Medicare Hospice Benefit was initially established in 1983. Hospice care is an approach to treatment that recognizes that the impending death of an individual warrants a change in focus from curative care to palliative care. The goal of hospice care is to help terminally ill individuals continue life with minimal disruption in normal activities while remaining primarily in the home environment.

To be eligible for hospice under Medicare, you must be certified by a physician to be terminally ill with a prognosis of 6-months or less to live if the terminal condition runs its normal course. Previous Medicare reviews in Puerto Rico have shown that the program benefit is subject to abuse by enrolling Medicare beneficiaries in hospice care who do not meet Medicare eligibility requirements.

There are four levels of care into which each day of care is classified: routine care, continuous care home care, inpatient respite care, and general inpatient care. For each day that a patient is under the care of a hospice, the hospice will be reimbursed a fixed amount applicable to the type and intensity of services furnished.

Our reviews in Puerto Rico focused on beneficiary enrollments who are active in hospice with more than 210 days of hospice care and those who were discharged for reasons other than death within the specified time periods. Reviews of medical records performed by Peer Review Organization physicians show that a large percentage of beneficiaries are not eligible for the hospice benefit and recommendations were made to the Regional Home Health Intermediary and HCFA to collect improper payments and improve program guidelines.

HOME HEALTH CARE - Eligibility

The Medicare home health benefit allows beneficiaries with limited mobility to live independently while still receiving professional health care services. The health care services are provided by a home health agency (HHA) in the home on a visiting basis.

Most Medicare reimbursement for home health services is covered under Part A hospital insurance. Medicare reimburses HHAs on a reasonable cost basis for costs related to visits for patient care. Home health care is not limited to a specific period of time or number of visits; eligible beneficiaries may receive care as long as it is reasonable and necessary.

In order for home health services to be covered by Medicare, beneficiaries must be (1) confined to their homes (homebound); (2) under the care of a physician; and (3) in need of skilled nursing services on an intermittent basis or physical or speech therapy. A plan of care must be established and certified by a physician. The beneficiary's health status and medical need as reflected in the plan of care and medical record provide the basis for determining whether the services rendered are reasonable and necessary.

We performed audits to determine whether payments to HHAs met the Medicare reimbursement requirements. These audits were performed in 5 States and included 10 HHAs. The financial impact of these reviews could total as much as $65 million.

Generally, our reviews consisted of: interviewing the beneficiary or a knowledgeable acquaintance; obtaining medical records from the HHAs and requesting HCFA's fiscal intermediaries' medical personnel to determine the medical need for services; and interviewing the physician who certified the beneficiary's plan of care.

Our reviews showed that claims were ineligible for Medicare reimbursement because (1) beneficiaries did not require skilled nursing services or physical or speech therapy; (2) beneficiaries were not homebound; (3) some services were medically unnecessary, excessive, or not supported by documentation in the medical records; and (4) some services were either not provided or were provided less frequently than actually claimed.

THE MANAGED CARE - Payment of Enhanced Rates

Managed Care enrollment is a growing portion of the Medicare program. In 1996, over four million Medicare beneficiaries were enrolled in a managed care program. This is about a 30 percent increase since 1994. About 75 percent of the Medicare population have a managed care program available to them as an option.

Audit work has focused on the increased payments made to these managed care companies for certain categories of beneficiaries. For example, beneficiaries with End Stage Renal Disease, those who reside in an institution (such as a nursing home), and persons who are dually eligible for Medicare and Medicaid would all trigger an enhanced payment to the managed care provider of service. Audit results have shown that Medicare has made these increased payments for people not actually in those special categories.

Within the Medicaid program, waivers are granted to States who wish to place recipients in a managed care program. It is possible that within the waiver agreement, special enhanced payments are authorized to managed care providers similar to those allowed in the Medicare program or for other reasons. State and internal auditors might want to review their managed care programs to determine whether there are enhanced rates being paid and whether similar conditions exist. Based on our Medicare work, these increased payments are vulnerable to being incorrectly paid.