Department of Health and Human Services

Office of Inspector General

Cost-Saver Handbook

THE 2002

RED BOOK

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Inspector General

OFFICE OF INSPECTOR GENERAL

Under the authority of the IG Act, we improve HHS programs and operations and protect them against fraud, waste, and abuse. By conducting independent and objective audits, evaluations, and investigations, we provide timely, useful, and reliable information and advice to Department officials, the Administration, the Congress, and the public. Our statutory mission is carried out by the following operating components:

Office of Audit Services

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

Office of Evaluation and Inspections

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

Office of Investigations

The OIG's Office of Investigations (OI) conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. The investigative efforts of OI lead to criminal convictions, administrative sanctions, or civil monetary penalties. The OI also oversees State Medicaid fraud control units which investigate and prosecute fraud and patient abuse in the Medicaid program.

Office of Counsel to the Inspector General

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

Introduction to the Red Book

Purpose of the Red Book

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

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

The savings estimates indicated for these unimplemented recommendations are updated from time to time to reflect more current information as it becomes available. The estimates have varying levels of precision. Full implementation of the recommendations in this 2002 edition of the *Red Book* could produce substantial savings to the Department.

Department of Health and Human Services

The Department of Health and Human Services (HHS) promotes the health and welfare of Americans and provides essential services to people of every age group. Over 80 percent of the HHS budget provides medical care coverage for the elderly, the disabled, and the poor. The balance of the programs support research into the causes of disease, promote preventive health measures, support the provision of health and social services, and combat alcoholism and drug abuse.

The Department's major operating divisions are briefly described below:

- The Centers for Medicare and Medicaid Services administers the Medicare, Medicaid, and State Children's Health Insurance programs.

- The public health agencies include the National Institutes of Health, the Food and Drug Administration, the Centers for Disease Control and Prevention, the Health Resources and Services Administration, the Indian Health Service, the Agency for Toxic

Substances and Disease Registry, the Agency for Healthcare Research and Quality, and the Substance Abuse and Mental Health Services Administration. They promote biomedical research and disease cure and prevention; ensure the safety and efficacy of marketed food, drugs, and medical devices; measure the impact of toxic waste sites on health; and conduct other activities designed to ensure the general health and safety of American citizens.

- The Administration for Children and Families provides Federal direction and funding for State-administered programs designed to promote stability, economic security, responsibility, and self-support for the Nation's families, including a variety of social service programs for American children and families, Native Americans, and the developmentally disabled.

Organization of the Red Book

The following sections of the *Red Book* address the OIG's recommendations to the Department's major operating divisions. Recommendations issued since the last *Red Book* was published are included in the first section; previously published recommendations can be found in the second.

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

Each final report, including the full text of comments from the cognizant agency, is available upon request. Each report also includes an appendix detailing OIG's methodology for estimating cost savings; we encourage the reader interested in a particular proposal to review the report.

We hope that this 2002 edition of the *Red Book* will prove to be a useful asset for departmental decision-makers, the Administration, and the Congress in their continuing efforts to contain costs and improve program efficiency at HHS.

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These estimated savings have varying levels of precision. Further, the actual savings to be achieved depend on the specific legislative, regulatory, or administrative action taken. However, the estimates listed provide a general indication of the magnitude of savings possible.

Centers for Medicare and Medicaid Services

Overview

The Centers for Medicare and Medicaid Services (CMS) administers the Medicare, Medicaid, and State Children's Health Insurance programs. Medicare Part A provides hospital and other institutional insurance for persons age 65 or older and for certain disabled persons, including those with end stage renal disease, and is financed primarily by payroll tax deductions through the Federal Hospital Insurance Trust Fund. Medicare Part B (Supplementary Medical Insurance), which is financed by participants and general revenues, is an optional program which covers most of the costs of medically necessary physician and other services.

The Medicaid program provides grants to States for medical care for qualifying low-income and other vulnerable people. State expenditures for medical assistance are matched by the Federal Government using a formula that measures per capita income in each State relative to the national average. The State Children's Health Insurance Program expands health coverage to uninsured children whose families earn too much to qualify for Medicaid but too little to afford private coverage.

Significant OIG Activities

Over the years, OIG findings and recommendations have contributed to many significant reforms in the Medicare program. Such reforms include implementation of the prospective payment system for inpatient hospital services and a fee schedule for physician services, the Clinical Laboratory Improvement Amendments of 1988, regional consolidation of claims processing for durable medical equipment, and new payment methodologies for graduate medical education.

The unimplemented OIG recommendations in this *Red Book* that relate to CMS activities could produce significant annual savings and recoveries to the Department. The OIG has identified a number of significant Medicare policy issues, such as modifying payments to managed care organizations, revising prescription drug payment methods, and ensuring the appropriateness of payments for mental health services. Regarding Medicaid, the OIG has recommended revising the limit on enhanced payments, establishing a more realistic drug rebate, and installing edits to preclude improper payment for laboratory services.

COLLECT OVERPAYMENTS FOR PROSPECTIVE PAYMENT SYSTEM TRANSFERS INCORRECTLY REPORTED AS DISCHARGES

Current Law:

In implementing the Medicare Part A prospective payment system, CMS issued 42 CFR 412.4, which sets forth the basic rules for patient transfers. Section 412.4(b) states that a discharge of a hospital inpatient is considered to be a transfer if the discharge is made from a hospital to another hospital that is paid under the prospective payment system or that is excluded from the payment system because of participation in an approved Statewide cost control program.

Proposal:

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

Legislative	Regulatory	Other Administrative
☐	☐	✓

Reason for Action:

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

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
TBD	TBD	TBD	TBD	TBD

Status:

The CMS concurred with our recommendation to collect potential overpayments but stated that it would initially limit the recovery effort to the last 4 years to comply with the cost report reopening period designated in 42 CFR 405.750. In September 2001, CMS advised the intermediaries to recover overpayments on the claims we identified that were 4 years old or less from the date of initial determination (bill processing date). Medicare regulations allow CMS to reopen claims up to 4 years after the date of initial determination upon establishment of good cause and up to any time when the payment decision involves fraud or similar fault. The CMS and OIG are conducting further reviews to determine whether any of the cases that occurred beyond 4 years merit reopening under the regulations. As we provide the information, the intermediaries are beginning to recover overpayments.

Report:

A-06-00-00041 (Final report, Nov. 2001)

MORE CLOSELY MONITOR 1-DAY INPATIENT HOSPITAL STAYS

Current Law:

Under the prospective payment system, hospitals are reimbursed for each admission when the patient is discharged based on established rates which are grouped into diagnosis-related groups (DRGs). Hospitals generally receive the full DRG payment for each discharge regardless of the beneficiary's length of stay in the hospital.

Proposal:

The CMS should expand its initiative begun in a limited number of States to conduct 1-day inpatient hospital stay reviews on a nationwide basis.

Legislative	Regulatory	Other Administrative
☐	☐	☑

Reason for Action:

The number of 1-day inpatient stays has increased significantly over the past several years. Such stays, many of which are observational stays, are vulnerable to billing errors. There is concern that the number of 1-day inpatient stays may continue to increase since the new hospital outpatient prospective payment system does not reimburse separately for observational stays; as a result, hospitals could inappropriately code these stays as inpatient stays.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
TBD	TBD	TBD	TBD	TBD

Status:

Recognizing that 1-day inpatient stays may represent a current problem, CMS agreed to instruct the peer review organizations to include these stays in their analysis.

Report:

A-05-89-00055 (Final report, July 1989)
A-05-92-00006 (Final report, Jan. 1992)
A-03-00-00007 (Final report, Apr. 2001)

PREVENT OVERPAYMENTS UNDER MEDICARE'S POSTACUTE CARE TRANSFER POLICY

Current Law:

The Balanced Budget Act of 1997 required implementation of a transfer policy to reduce inpatient payment rates when prospective payment system hospitals discharge beneficiaries in specified DRGs to certain postacute care settings.

Proposal:

The CMS should establish edits in the Common Working File to compare beneficiary inpatient claims potentially subject to the postacute care transfer policy with subsequent postacute claims.

Legislative	Regulatory	Other Administrative
☐	☐	☑

Reason for Action:

We estimated that for Fiscal Year (FY) 1999 the Medicare program paid approximately $55.2 million in excessive payments to prospective payment system hospitals as a result of these erroneously coded discharges. Our reviews indicated that the Common Working File had no controls or edits in place to prevent excessive payments to such hospitals for erroneously coded qualified discharges that are followed by postacute care.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$55.2	$55.2	$55.2	$55.2	$55.2

Status:

The CMS concurred with our recommendations. Until the edits are in place, we will continue our work to identify additional overpayments.

Report:

A-04-00-01210 (Final report, Dec. 2000)
A-04-00-02162 (Final report, Feb. 2001)
A-04-00-01220 (Final report, Oct. 2001)

IDENTIFY MEDICAL EQUIPMENT/SUPPLY CLAIMS LACKING VALID, ACTIVE UNIQUE PHYSICIAN IDENTIFICATION NUMBERS

Current Law:

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

Proposal:

The CMS should create edits to identify medical equipment and supply claims that do not have a valid and active physician identification number listed for the ordering physician.

Legislative	Regulatory	Other Administrative
☐	☐	☑

Reason for Action:

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

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$91	$91	$91	$91	$91

Status:

The CMS concurred with our recommendation. The agency planned to implement an edit to reject claims listing a deceased physician's identification number beginning in April 2002 and to later expand this edit to include all inactive and invalid physician identification numbers.

Report:

OEI-03-01-00110 (Final report, Nov. 2001)

PREVENT INAPPROPRIATE MEDICARE PART B PAYMENTS FOR MEDICAL EQUIPMENT IN SKILLED NURSING FACILITIES

Current Law:

Federal law, regulations, and guidelines prohibit certain Medicare Part B durable medical equipment (DME) payments on behalf of beneficiaries who are in qualifying Medicare Part A skilled nursing facilities for an entire month.

Proposal:

The CMS should work with the DME regional carriers to implement edits to prevent inappropriate Medicare Part B DME payments for beneficiaries who are residents of skilled nursing facilities for an entire month.

Legislative	Regulatory	Other Administrative
☐	☐	☑

Reason for Action:

Our review identified approximately $35 million in inappropriate Medicare Part B payments for Calendar Years (CY) 1996 through 1998.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$11.7	$11.7	$11.7	$11.7	$11.7

Status:

The CMS did not concur with our recommendation to install postpayment edits and stated that it would be impractical for the regional carriers to perform postpayment reviews to identify these situations. The CMS has developed prepayment edits, which were expected to be implemented in April 2002.

Report:

A-01-00-00509 (Final report, July 2001)

RECLASSIFY RESPIRATORY ASSIST DEVICES WITH A BACK-UP RATE

Current Law:

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

Proposal:

The CMS should reclassify bi-level respiratory assist devices with a back-up rate from the "frequent and substantial servicing" category to the "capped rental" category under the durable medical device benefit.

Legislative	Regulatory	Other Administrative
☐	☑	☐

Reason for Action:

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

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$11.5	$11.5	$11.5	$11.5	$11.5

Status:

The CMS concurred with our recommendation.

Report:

OEI-07-99-00440 (Final report, June 2001)

ADJUST HOME HEALTH AGENCY PROSPECTIVE PAYMENTS

Current Law:

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

Proposal:

The CMS should adjust for the costs of unnecessary services and other improper payments and eliminate them from the prospective payment system rates for home health agencies.

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

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

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
TBD	TBD	TBD	TBD	TBD

Status:

While recognizing that the issue merits further review, CMS disagreed with our recommendation because it believes that actions have already been taken to ensure accurate and fair payments. The CMS believes that several factors nullify any need for further payment rate changes, including the future imposition by the Congress of a 15-percent reduction in future home health payments. The Congress has delayed the date for imposing this reduction.

Report:

A-04-99-01194 (Final report, Nov. 1999)

ENSURE APPROPRIATENESS OF MEDICARE PAYMENTS FOR MENTAL HEALTH SERVICES

Current Law:

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

Proposal:

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

Legislative	Regulatory	Other Administrative
☐	☐	☑

Reason for Action:

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

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

Savings (in millions):*

FY 1	FY 2	FY 3	FY 4	FY 5
$685	$685	$685	$685	$685

**Includes $224 million for acute hospital outpatient services, $189 million for partial hospitalization in community mental health centers, $57 million for psychiatric hospital outpatient services, $30 million for nursing home services, and $185 million for other mental health services.*

Status:

Concurring with the individual reports, CMS has initiated some efforts, particularly regarding community mental health centers.

Report:

A-04-98-02145 (Final report, Oct. 1998)
A-01-99-00507 (Final report, Mar. 2000)
A-01-99-00530 (Final report, Dec. 2000)
OEI-02-99-00140 (Final report, Jan. 2001)
OEI-03-99-00130 (Final report, May 2001)

PREVENT OVERPAYMENTS OF RURAL HEALTH CLINIC CLAIMS

Current Law:

The Rural Health Clinics Act of 1977 was to address an inadequate supply of physicians who serve Medicare and Medicaid beneficiaries in rural areas. The act expanded reimbursement in the rural health clinic setting to include services provided by nonphysician practitioners. Fiscal intermediaries reimburse clinics a prospective amount per patient encounter based on the clinic's actual costs.

Proposal:

The CMS should design and implement Common Working File edits to detect claims containing Part B services that were paid as, or as part of, rural health clinic encounter claims.

Legislative	Regulatory	Other Administrative
☐	☐	☑

Reason for Action:

For 13 selected States, our review identified claims containing potential Medicare overpayments totaling about $2.8 million.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$0.93	$0.93	$0.93	$0.93	$0.93

Status:

The CMS did not concur with our recommendation, stating that it would impose an undue hardship to mandate the same extensive cost reporting requirements imposed on hospitals and other health care facilities participating in the Medicare program.

Report:

A-07-00-00108 (Final report, Oct. 2001)

REVISE THE LIMIT ON MEDICAID ENHANCED PAYMENTS

Current Law:

In a final rule published in January 2001, CMS revised the Medicaid upper payment limit regulations to provide for three separate aggregate upper limits--one each for private, State, and non-State government facilities. The CMS created an exception for payments to non-State government-owned or -operated hospitals. This exemption provided that the aggregate Medicaid payments to those hospitals may not exceed 150 percent of a reasonable estimate of the amount that would be paid for the hospitals' services under Medicare payment principles.

Proposal:

The CMS should reconsider capping the aggregate upper payment limit at 100 percent for all facilities, rather than the 150 percent allowance for non-State government hospitals.

Legislative	Regulatory	Other Administrative
☐	☑	☐

Reason for Action:

Based on our review of the States' use of intergovernmental transfers to finance enhanced payments to county or local government-owned facilities, we believe that the higher aggregate payment limit for non-State government hospitals has not been adequately supported through an analysis of these hospitals' financial operations.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$1,800	$1,800	$1,800	$1,800	$1,800

Status:

The CMS concurred with our recommendation and, in January 2002, issued a final rule to reduce the 150 percent upper payment limit to 100 percent. However, due to a court prohibition, this rule has not yet been implemented.

Report:

A-03-00-00216 (Final report, Sept. 2001)

ELIMINATE OR REDUCE TRANSITION PERIODS FOR COMPLIANCE WITH NEW MEDICAID UPPER PAYMENT LIMITS

Current Law:

In a final rule published in January 2001, CMS revised the Medicaid upper payment limit regulations to provide for three separate aggregate upper limits--one each for private, State, and non-State government facilities. The rule included several transition periods for States with approved rate enhancement State plan amendments. Depending on the effective date of these amendments, States had 2 to 8 years to comply with the new upper limits.

Proposal:

The CMS should seek authority to eliminate or reduce the transition periods included in the new upper payment limit regulations.

Legislative	Regulatory	Other Administrative
☐	✓	✓

Reason for Action:

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

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
TBD	TBD	TBD	TBD	TBD

Status:

The CMS did not concur with our recommendation. According to CMS, the transition periods were established pursuant to either notice-and-comment rulemaking or legislation, and offering new proposals at this time would undermine the consensus reached through those processes. Accordingly, the President's FY 2003 budget does not include our recommended proposal.

Report:

A-03-00-00216 (Final report, Sept. 2001)

DELAY OR REPEAL THE INCREASE IN MEDICAID DISPROPORTIONATE SHARE HOSPITAL PAYMENTS

Current Law:

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

Proposal:

The CMS should seek legislation to at least delay, if not repeal, the implementation of the increased DSH limit until the need for and use of DSH funds for the actual direct care of uninsured patients can be sufficiently reviewed. If the new limit is implemented, CMS should consider seeking legislative reform to ensure that DSH funds remain at the hospitals to provide care to vulnerable populations, rather than being returned to the States through intergovernmental transfers. The OIG also believes that any Medicaid payment returned by a provider to the State should be treated as a credit applicable to the Medicaid program. The CMS should also perform any other studies of the DSH program that it deems appropriate to evaluate the reasonableness of DSH reimbursement.

Legislative	Regulatory	Other Administrative
✓		✓

Reason for Action:

Based on audits in four States, we believe that DSH payments are not always retained and used by public hospitals and that the DSH funds received are not always calculated correctly. We are concerned that by raising the limit to 175 percent, additional DSH funds may not actually be retained by public hospitals or the amount of incorrect DSH payments may increase.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$50	$190	$140		

Status:

The CMS initially concurred with our recommendations. However, when commenting on the final report, CMS stated that the President's FY 2003 budget does not seek a change in DSH legislation.

Report:

A-06-01-00069 (Final report, Dec. 2001)

REQUIRE THAT MEDICAID REIMBURSEMENT FOR BRAND NAME DRUGS BE MORE IN LINE WITH ACQUISITION COSTS

Current Law:

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

Proposal:

The CMS should require the States to bring pharmacy reimbursement more in line with the actual acquisition cost of brand name drugs being realized by pharmacies in their States.

Legislative	Regulatory	Other Administrative
☐	☐	✓

Reason for Action:

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

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$1,080	$1,080	$1,080	$1,080	$1,080

Status:

The CMS concurred with our recommendation and is working with States to review their estimates of acquisition costs in light of our findings. However, our proposal was not included in the President's FY 2003 budget.

Report:

A-06-00-00023 (Final report, Aug. 2001)

REQUIRE THAT MEDICAID REIMBURSEMENT FOR GENERIC DRUGS BE MORE IN LINE WITH ACQUISITION COSTS

Current Law:

Most States use AWP minus a percentage discount, which varies by State, as a basis for reimbursing pharmacies for drug prescriptions.

Proposal:

The CMS should require the States to bring pharmacy reimbursement more in line with the actual acquisition cost of generic drugs being realized by pharmacies in their States.

Legislative	Regulatory	Other Administrative
☐	☐	✓

Reason for Action:

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

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$470	$470	$470	$470	$470

Status:

The CMS concurred with our recommendation. The agency is working with States to strongly encourage them to review their estimates of acquisition costs and will follow up to ensure that they take our findings into account. However, our proposal was not included in the President's FY 2003 budget.

Report:

A-06-01-00053 (Final report, Mar. 2002)

REVIEW MEDICAID REIMBURSEMENT METHODOLOGY FOR HIV/AIDS DRUGS

Current Law:

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

Proposal:

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

Legislative	Regulatory	Other Administrative
✓		✓

Reason for Action:

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

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$140	$140	$140	$140	$140

Status:

The CMS no longer believes that the recommended change is necessary. The agency believes that reimbursement changes will occur through revised AWPs, based on the President's budget proposal for a legislative change that would base the Medicaid drug rebate on the difference between AWP and the best price for a drug.

Report:

OEI-05-99-00611 (Final report, July 2001)

REVIEW COST EFFECTIVENESS OF "PAY AND CHASE" METHODS FOR MEDICAID PHARMACY THIRD-PARTY LIABILITY RECOVERIES

Current Law:

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

Proposal:

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

Legislative	Regulatory	Other Administrative
☐	☐	✓

Reason for Action:

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

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$185	$185	$185	$185	$185

Status:

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

Report:

OEI-03-00-00030 (Final report, Aug. 2001)

CONTINUE MANDATED REDUCTIONS IN HOSPITAL CAPITAL COSTS

Current Law:

On October 1, 1991, CMS began a 10-year transition period for paying inpatient hospital capital-related costs under a prospective payment system. Final regulations were promulgated August 30, 1991 (56FR43358). The rates are based on historical costs, less a mandated reduction of 7.4 percent under the Omnibus Budget Reconciliation Act of 1993.

Proposal:

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

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

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

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$820	$950	$1,140	$1,450	$1,840

Status:

The CMS did not agree with our recommendation. Although the Balanced Budget Act of 1997 reduced capital payments, it did not include the effect of excess bed capacity and other elements included in the base-year historical costs. The President's FY 2001 budget proposed reducing capital payments and saving $630 million in FY 2001 through FY 2005.

Report:

A-09-91-00070 (Final report, Apr. 1992)
A-14-93-00380 (Final report, Apr. 1993)

MORE ACCURATELY REFLECT BASE-YEAR COSTS IN PROSPECTIVE PAYMENT SYSTEM'S CAPITAL COST RATES

Current Law:

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

Proposal:

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

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

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

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$249	$284	$319	$354	$388

Status:

The CMS agreed that the capital rate reflected an overestimation of base-year costs, and the Balanced Budget Act of 1997 provided for a reduction in capital payments for 1998-2002. However, we believe that CMS should continue to monitor current data since additional reductions may be warranted in the future.

Report:

A-07-95-01127 (Final report, Aug. 1995)

REDUCE THE PROSPECTIVE PAYMENT SYSTEM ADJUSTMENT FACTOR FOR INDIRECT MEDICAL EDUCATION COSTS

Current Law:

Since the inception of the Medicare prospective payment system, indirect medical education payments have been paid only to teaching hospitals to address the presumably higher costs incurred by these hospitals. The CMS and the Congress determined indirect medical education adjustment factor. Using historical data and regression analysis, CMS compared costs per case in teaching and nonteaching hospitals and determined that operating costs in hospitals with teaching programs increased approximately 5.79 percent for every 0.1 resident physician per hospital bed compared with hospitals without teaching programs. Under a congressional mandate, CMS was required to double the adjustment factor under the prospective payment system--increasing it to 11.59 percent.

The Consolidated Omnibus Budget Reconciliation Act of 1985 reduced the indirect medical education adjustment factor from 11.59 percent to 8.1 percent for discharges occurring on or after May 1, 1986, and before October 1, 1988. The Omnibus Budget Reconciliation Act of 1987 further modified the adjustment by reducing it to approximately 7.7 percent for each 0.1 in the ratio of interns and residents to beds.

Proposal:

The indirect medical education adjustment factor should be reduced to the level supported by CMS empirical data, and further studies should be made to determine whether different adjustment factors are warranted for different types of teaching hospitals.

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

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

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
TBD	TBD	TBD	TBD	TBD

Status:

The CMS agreed with our recommendation. In addition, the Balanced Budget Act of 1997 (as amended by the Balanced Budget Refinement Act of 1999) reduced the indirect medical education adjustment factor from 7.7 percent in FY 1997 to 5.5 percent in 2002 and thereafter. We believe that the factor should be further reduced to eliminate any overlap with the disproportionate share adjustment.

Report:

A-07-88-00111 (Final report, Sept. 1989)

REVISE GRADUATE MEDICAL EDUCATION PAYMENT METHODOLOGY

Current Law:

Section 9202 of the Consolidated Omnibus Budget Reconciliation Act of 1985 and section 9314 of the Omnibus Budget Reconciliation Act of 1986 changed the way Medicare reimburses hospitals for the direct cost of graduate medical education. Under the revised methodology, costs are reimbursed on a "hospital specific" prospective payment basis, which is retroactive to cost reporting periods beginning on or after July 1, 1985.

Proposal:

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

Legislative	Regulatory	Other Administrative
✓	✓	

Reason for Action:

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

Savings (in millions):

	FY 1	FY 2	FY 3	FY 4	FY 5
Factor 1	$ 39.2	$ 39.2	$ 39.2	$ 39.2	$ 39.2
Factor 2	125.6	125.6	125.6	125.6	125.6
Combined *	157.3	157.3	157.3	157.3	157.3

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

Status:

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

Report:

A-06-92-00020 (Final report, Apr. 1994)

DENY MEDICARE REIMBURSEMENT FOR PATIENTS WHO RECEIVE SUBSTANDARD MEDICAL CARE

Current Law:

Under Medicare, hospitals receive a pre-established payment for each discharge based on an assigned DRG. Each DRG results in an associated payment that represents an average cost for patients having similar diagnoses. The Congress established peer review organizations to protect the integrity of the prospective payment system and to maintain the quality of care. The Consolidated Omnibus Budget Reconciliation Act of 1985 authorized these organizations to deny Medicare reimbursement for patients receiving substandard medical care, defined as medical care clearly failing to meet professionally recognized standards.

Proposal:

The CMS should increase efforts to identify and address poor quality care in hospitals by issuing regulations to implement the provisions of the 1985 act.

Legislative	Regulatory	Other Administrative
☐	✓	☐

Reason for Action:

Of the patients sampled, 6.6 percent received poor quality of care.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
TBD	TBD	TBD	TBD	TBD

Status:

In 1989, CMS issued a notice of proposed rulemaking to authorize the peer review organizations to deny Medicare reimbursement for patients who received substandard medical care. The CMS has not yet issued a final regulation.

Report:

OEI-09-88-00870 (Final report, July 1989)

MODIFY PAYMENT POLICY FOR MEDICARE BAD DEBTS

Current Law:

Under Medicare's inpatient hospital prospective payment system, hospitals are reimbursed for inpatient services rendered to Medicare beneficiaries by a fixed payment amount based on a DRG. However, bad debts related to unpaid deductible and coinsurance amounts are reimbursed separately as pass-through items (i.e., reimbursed outside the DRG) under reasonable cost principles.

Proposal:

We presented an analysis of four options for CMS to consider, including the elimination of a separate payment for bad debts, the offset of Medicare bad debts against beneficiary Social Security payments, the limitation of bad debt payments to prospective payment system hospitals that are profitable in Medicare operations, and the inclusion of a bad debt factor in the DRG rates. The CMS should seek legislative authority to further modify bad debt policies.

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

The CMS records showed that total Medicare bad debts increased from $366 million in FY 1993 to almost $574 million in FY 1997. During this same period, hospitals continued to earn significant profits. Also, hospital bad debt collection efforts have often been less than adequate since there is little incentive for hospitals to collect the unpaid deductible and coinsurance amounts when Medicare pays these amounts.

Savings (in millions):*

FY 1	FY 2	FY 3	FY 4	FY 5
$340	$485	$485	$485	$485

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

Status:

In responding to our report, CMS agreed with the recommendation to include a bad debt factor in the DRG rates. The Balanced Budget Act of 1997 provided for some reduction of bad debt payments to providers. The Benefits Improvement and Protection Act of 2000 subsequently increased bad debt reimbursement. Additional legislative changes are needed to implement the modifications we recommended.

Report:

A-14-90-00339 (Final report, June 1990)

MORE CLOSELY MONITOR SAME-DAY HOSPITAL READMISSIONS

Current Law:

The Social Security Amendments of 1983 provided for establishing a prospective payment system for Medicare payment of the operating costs of inpatient hospital services. Under this system, hospitals are paid a predetermined rate for each patient discharge. In the past, peer review organizations regularly reviewed a CMS-generated sample of hospital readmission claims to determine whether patients were prematurely discharged from the first confinement, thus causing a readmission. These regular reviews were discontinued in 1993, but the peer review organizations continue to make retrospective reviews of premature discharges in other contexts.

Proposal:

The CMS should work with OIG in reviewing hospital readmissions to identify overpayments, monitor the quality of hospital care, profile aberrant hospital providers, and ensure that corrective action plans are instituted and appropriate referrals are made to the OIG. The CMS should also reinstate hospital readmission reviews by peer review organizations.

Legislative	Regulatory	Other Administrative
☐	☐	☑

Reason for Action:

Hospital readmissions to the same prospective payment system hospital on the same day of discharge are vulnerable to improper payments and may be indicative of problems with quality of care, such as premature hospital discharges. Other problems include separate claims for one continuous stay, medically unnecessary readmissions for services that could have been provided in a less acute setting, and DRG upcoding.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$22	$22	$22	$22	$22

Status:

The CMS agreed to further work with OIG to better monitor quality-of-care and overpayment issues associated with hospital readmissions. At CMS's request, OIG provided CMS with further analysis of the patterns of readmissions.

Report:

A-01-98-00504 (Final report, May 1999)
A-14-99-00401 (Final report, Feb. 2000)

RECOVER OVERPAYMENTS AND EXPAND THE DIAGNOSIS-RELATED GROUP PAYMENT WINDOW

Current Law:

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

Proposal:

The CMS should propose legislation to expand the DRG payment window to at least 7 days immediately before the day of admission.

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

Our review identified about $83.5 million in admission-related nonphysician outpatient services rendered 4 to 7 days immediately before an inpatient admission. Since the intent of the prospective payment system has always been to include related services under one prospective payment, it would seem appropriate that the DRG payment window encompass a longer period.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$83.5	$83.5	$83.5	$83.5	$83.5

Status:

The CMS did not concur with the recommendation, and no legislative proposal was included in the President's FY 2001 budget.

Report:

A-01-92-00521 (Final report, July 1994)

REDUCE MEDICARE PAYMENTS FOR HOSPITAL OUTPATIENT SERVICES

Current Law:

To bring payments for services in hospital outpatient departments more in line with payments for services in an ambulatory surgical center, the Omnibus Budget Reconciliation Act of 1990, section 4151, reduced Medicare payments for hospital outpatient services by (1) adjusting the payment formula to 58 percent of the ambulatory surgical center rates and 42 percent of the hospital's outpatient costs and (2) lowering hospital payments made on a reasonable cost basis by 5.8 percent. The Omnibus Budget Reconciliation Act of 1993 extended the 5.8-percent reduction in payments for hospital outpatient department services from FY 1996 through 1998. The prospective payment system for these services became effective August 1, 2000.

Proposal:

Legislation is needed to reduce current payments for services in outpatient departments to bring them more in line with ambulatory service center approved payments. We recommended paying outpatient departments the ambulatory service center approved rate or adjusting hospital payments by a uniform percentage.

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

Our study of hospital outpatient surgeries showed that the current blended rate to hospitals, in the aggregate, is greater than the payment rate for ambulatory surgical center approved services. We analyzed over 2 million hospital outpatient bills containing ambulatory center approved surgeries from 5,421 hospitals. The disparity between Medicare payments to outpatient departments and the centers for similar services still exists.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$90	$107	$126	$147	$175

Status:

The CMS acknowledged that our report would be helpful in developing a legislative proposal to bring about greater parity of payments for services performed in an outpatient setting and those performed in ambulatory surgical centers. Included in the Balanced Budget Act of 1997 was the requirement to develop a prospective payment system for hospital outpatient services, as well as provisions to eliminate a formula-driven overpayment. We are assessing the system's initial implementation procedures.

Report:

A-14-89-00221 (Final report, Mar. 1991)
A-14-98-00400 (Final report, Nov. 1998)
OEI-09-88-01003 (Final report, May 1989)

ADJUST BASE-YEAR COSTS IN THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES

Current Law:

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

Proposal:

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

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

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

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
TBD	TBD	TBD	TBD	TBD

Status:

The CMS agreed with our recommendations and stated that further work should be done to examine the adequacy of base-year costs.

Report:

A-14-98-00400 (Final report, Nov. 1998)

PRECLUDE PAYMENT FOR MUTUALLY EXCLUSIVE PROCEDURE CODES FOR HOSPITAL OUTPATIENT SERVICES

Current Law:

The CMS requires Medicare carriers to implement edits for mutually exclusive procedure codes in their claim processing systems. Mutually exclusive procedure codes represent medical services that cannot reasonably be performed in the same session to the same patient by the same provider. When the edits identify pairs of mutually exclusive codes, the procedure with the lowest work-relative value unit is allowed and the matching procedure is denied.

Proposal:

The CMS should instruct fiscal intermediaries to implement edits to preclude payment for Medicare Part B mutually exclusive procedure codes and notify hospital providers that Medicare Part B will no longer pay for mutually exclusive procedure codes related to radiology and pathology/laboratory services.

Legislative	Regulatory	Other Administrative
☐	☐	☑

Reason for Action:

While CMS established edits to preclude payment for certain Medicare Part B mutually exclusive services provided in doctors' offices or clinics, payment was not prevented for the same types of services provided in hospital outpatient departments. Of particular dollar significance was payment for mutually exclusive radiology and pathology/laboratory services. Unlike Medicare carriers, fiscal intermediaries were not provided written instructions to implement edits that would preclude payment of mutually exclusive procedure codes to hospital outpatient departments.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$14.55	$14.55	$14.55	$14.55	$14.55

Status:

The CMS agreed to instruct fiscal intermediaries to implement edits addressing mutually exclusive procedure codes. The edits for hospital outpatient services were implemented as a component of the correct coding initiative edits when the new outpatient prospective payment system was implemented, effective August 1, 2000. The CMS also agreed to notify hospitals that Medicare Part B would no longer pay for mutually exclusive procedure codes related to radiology and pathology/laboratory services.

Report:

A-01-98-00507 (Final report, May 1999)

APPLY A 190-DAY LIFETIME LIMIT FOR MEDICARE INPATIENT PSYCHIATRIC CARE AND A 60-DAY ANNUAL LIMIT

Current Law:

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

Proposal:

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

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

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

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$47.6	$47.6	$47.6	$47.6	$47.6

Status:

The CMS agreed with our findings but stated that further analysis would be required before any legislative changes could be supported.

Report:

A-06-86-62045 (Final report, Feb. 1988)

PRECLUDE IMPROPER PAYMENTS TO HOSPITALS FOR HOSPICE BENEFICIARIES

Current Law:

When a beneficiary elects hospice care, the Medicare program reimburses the hospice a fixed rate for each day of care. The hospice then assumes fiscal responsibility for all Medicare Part A services, including hospital services, related to the beneficiary's terminal illness. A separate Medicare payment to the hospital is not allowable; instead the hospital should bill the hospice, and the hospice then receives a higher daily rate for the number of days the hospice beneficiary is hospitalized.

Proposal:

The CMS should instruct its fiscal intermediaries to recover the improper payments noted in our review and to review related medical records for the potential inappropriate payments we identified.

Legislative	Regulatory	Other Administrative
☐	☐	☑

Reason for Action:

Our review showed that over $21 million in overpayments to hospitals should be recovered for CY 1988-1992. In addition, more effective edits of hospital/hospice claims could result in annual savings of approximately $4 million over the next 5 years.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$4	$4	$4	$4	$4

Status:

The CMS agreed to recover the overpayments identified and to instruct its fiscal intermediaries to review the claims that we identified as potential overpayments.

Report:

A-02-93-01029 (Final report, June 1995)

ELIMINATE PROVIDER-BASED DESIGNATIONS OR IMPROVE MANAGEMENT AND OVERSIGHT

Current Law:

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

Proposal:

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

Legislative	Regulatory	Other Administrative
✓		✓

Reason for Action:

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

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
TBD	TBD	TBD	TBD	TBD

Status:

The CMS published a final rule establishing strict criteria for obtaining provider-based status. The methodology for determining such status is undergoing clarification, and a provider-based questionnaire is being developed. All provider-based physician practices will be required to obtain provider-based designations from the CMS regional offices. As part of its proposed provider revalidation effort, CMS is considering collecting information on physician practices being billed as provider-based arrangements.

Report:

OEI-05-98-00110 (Final report, Sept. 1999)
OEI-04-97-00090 (Final report, Aug. 2000)

REQUIRE MEDICARE COVERAGE OF ALL STATE AND LOCAL GOVERNMENT EMPLOYEES OR MAKE MEDICARE THE SECONDARY PAYER

Current Law:

The Consolidated Omnibus Budget Reconciliation Act of 1985 established Medicare Part A coverage and payment of hospital insurance contributions for new State and local government employees hired after March 31, 1986. However, employees hired before April 1, 1986, are not covered by Medicare Part A unless the government entity has voluntarily agreed to cover groups of its employees under the full Old-Age, Survivors and Disability Insurance program or unless, with some exceptions, they were covered under a qualified retirement system offered by their employers. (See the Omnibus Budget Reconciliation Act of 1990.)

Proposal:

Medicare coverage and hospital insurance contributions should be required for all State and local employees, including those hired before April 1, 1986. If this proposal is not enacted, CMS should seek legislation making Medicare the secondary payer for retirees from exempt State and local agencies.

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

Retirees from exempt agencies paid significantly lower taxes than nonexempt retirees. We estimated that over a 9-year period (1982-1990), Medicare would have spent about $16.9 billion in benefits for these retirees. However, only an estimated $2.7 billion of taxes, with interest, would have been collected, leaving a shortfall of $14.2 billion to be subsidized by other taxpayers. Most of these retirees qualify for Medicare through other covered employment or as a spouse of a covered worker. Those insured through other employment contributed far less for their coverage than other retirees, yet their hospital benefit protection is the same. Furthermore, exempt government agencies that did not pay the employer's share of hospital insurance contributions will have the windfall advantage of Medicare as the primary payer of health costs for retirees over age 65. Both conditions unfairly drain the hospital insurance trust fund and are inequitable to employees and employers who must contribute.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$1,559	$1,552	$1,521	$1,490	$1,451

Status:

In responding to our report, CMS agreed with the recommendation to mandate Medicare coverage for all State and local government employees. However, the proposal was not included in the President's FY 2003 budget. The CMS did not agree with our recommendation to make Medicare the secondary payer, noting, among other things, that this would eventually be more costly for the exempt agencies than mandated coverage.

Report:

A-09-88-00072 (Final report, Feb. 1989)

SELECTIVELY CONTRACT FOR CORONARY ARTERY BYPASS GRAFT SURGERY

Current Law:

Medicare pays for coronary artery bypass graft surgery costs incurred for physician, hospital, and other services. Payment for hospitals is based on DRG rates, and payment for physician services is based on the applicable fee schedule.

Proposal:

The CMS should negotiate all-inclusive package payment prices with selected surgeons and medical centers for providing bypass surgery to Medicare beneficiaries.

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

Medicare paid over $1.5 billion in 1985 for bypass surgery (DRG codes 106 and 107) performed on about 63,000 beneficiaries. We found that hospitals and surgical teams that performed more than 200 of these surgeries a year had better outcomes in terms of mortality rates, lengths of stay, and charges. The reasonable charge allowances for physicians are often inconsistent and inequitable. Similarly, both inconsistent carrier controls/payment guidelines and the revised CMS procedure coding system have increased Medicare costs for this surgery. Current legislation does not allow the negotiation of preferred provider and fixed-price packages for bypass surgery for Medicare patients, despite the fact that these practices save the private sector millions of dollars each year.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$138	$138	$138	$138	$138

Status:

The CMS conducted a 5-year demonstration project which ended in December 1998. The Administration sought legislation to give CMS the authority to use selective contracting for bypass surgery and other procedures during the Balanced Budget Act deliberations. However, it was not approved. The President's FY 2001 budget again requested this authority.

Report:

OEI-09-89-00076 (Final report, Aug. 1987)

EXPAND NATIONAL LIST OF CHEMISTRY PANEL TESTS

Current Law:

Chemistry tests are clinical laboratory services requested by physicians in order to diagnose and treat patients. Chemistry tests that are commonly performed on automated laboratory equipment are referred to as panel tests and are required by CMS to be grouped together for payment purposes. In addition, CMS requires that other chemistry tests available in a carrier's service area and commonly performed on automated laboratory equipment be reimbursed as panel tests.

Proposal:

The CMS should update its guidelines by expanding the national list of chemistry panel tests to include 10 tests identified by our audit.

Legislative	Regulatory	Other Administrative
☐	☐	✓

Reason for Action:

Based on claims and responses to questionnaires by hospital and independent laboratories related to 18 tests identified for review, 10 are available in all carrier service areas and are commonly performed on automated equipment. These 10 tests should be paid as panel tests. However, CMS guidelines specifying chemistry tests that should be paneled by all carriers have not been updated promptly to add tests as technology has advanced.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$130	$130	$130	$130	$130

Status:

The CMS agreed with 8 of the 10 tests recommended for addition to the list and added 6 of these tests to its carrier manual. The CMS will periodically review applicable tests and related equipment. Also, although a legislative change was included in the President's 1997 budget, the Congress decided (through the Balanced Budget Act of 1997) to achieve savings through other means, including freezing laboratory payments through 2002 and reducing the national cap to 74 percent of the median of all fee schedules. A legislative proposal to reduce laboratory payments for four tests was included in the President's FY 2001 budget but was not enacted.

Report:

A-01-93-00521 (Final report, Jan. 1995)

ENCOURAGE PHYSICIANS TO SUBMIT PAPERLESS CLAIMS

Current Law:

Physicians may submit claims to Medicare in either paper or electronic form. In CY 1994, 73 percent of all physician claims were submitted electronically, and 59 percent of Medicare physicians used only paper. An approach for fostering standardization of electronic data interchange raised the rate of electronic media claims for assigned physicians to 81.3 percent in April 1999.

Proposal:

The CMS should:

- Lead a target outreach effort to encourage voluntary conversion to paperless Medicare claim filing by physicians who submit claims on paper and who have a moderate to high level of interest in making the switch. This effort should be coordinated with efforts to promote further use of electronic data interchange by providers under the administrative simplification provisions of the Health Insurance Portability and Accountability Act.

- Begin to plan now for the policy changes that will be necessary to achieve an almost completely paperless environment for processing Medicare claims. These policy changes can include targeting a date when all physicians will be mandated to submit paperless claims, targeting a date when paperless claim submission will become a condition for Medicare participating physician status, or continuing to accept paper claims but imposing a filing fee to cover the incremental cost of doing so.

Legislative	Regulatory	Other Administrative
✓		✓

Reason for Action:

Changes in the marketplace afford CMS an excellent opportunity to further extend electronic billing. Approximately 65 percent of physicians who submitted Medicare claims only on paper indicate a high or moderate level of interest in switching to paperless claims.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$126	$126	$126	$126	$126

Status:

The CMS concurred with our recommendations. The President's FY 2002 and 2003 budgets proposed to assess a $1.50 fee on most claims not submitted electronically. Also, as part of implementing the CMS Claims Processing User Fee Act of 2001, significant outreach activity to providers will be conducted. The CMS anticipates that the act's standards will eventually raise physician participation in electronic media claims.

Report:

A-05-94-00039 (Final report, May 1996)
OEI-01-94-00230 (Final report, May 1996)

MODIFY MEDICARE INCENTIVE PAYMENTS IN HEALTH PROFESSIONAL SHORTAGE AREAS

Current Law:

Since 1989, physicians who treat Medicare patients in HHS-defined health professional shortage areas have been entitled to bonus payments designed to improve patient access to care. The current law calls for a 10-percent bonus.

Proposal:

The CMS should seek to (1) eliminate the Medicare incentive payments entirely, (2) modify the Medicare incentive payment program to target it more effectively to primary care, or (3) channel funds from the Medicare incentive payment program to new or existing mechanisms for improving access to primary care.

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

A substantial amount of the Medicare incentive money has gone to physicians who provide little or no primary care. Also, among primary care physicians, Medicare incentive payments apparently have little effect on practice location decisions.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$90	$90	$90	$90	$90

Status:

The CMS concurred with our recommendation and had previously advanced legislation to provide larger bonuses for primary care services and to eliminate certain bonuses in urban areas. The President's FY 2001 budget proposed eliminating the bonus payments for non-primary-care physicians in urban areas.

Report:

OEI-01-93-00050 (Final report, June 1994)

REDUCE MEDICARE END STAGE RENAL DISEASE PAYMENT RATES

Current Law:

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

Proposal:

The CMS should reduce the payment rates for outpatient dialysis treatments to reflect current efficiencies and economies in the marketplace.

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

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

Savings (in millions):*

FY 1	FY 2	FY 3	FY 4	FY 5
$22	$22	$22	$22	$22

**This savings estimate represents program savings of $22 million for each dollar reduction in the composite rate.*

Status:

The CMS agreed that the composite payment rates should reflect the costs of outpatient dialysis treatment in efficiently operated facilities, and the Balanced Budget Act of 1997 required the Secretary to audit the cost reports of each dialysis provider at least once every 3 years. The Balanced Budget Refinement Act of 1999 increased each composite rate payment for dialysis services furnished during 2000 by 1.2 percent above the payment for services provided on December 31, 1999. The Benefits Improvement and Protection Act of 2000 increased the payment rate for services provided in 2001 by 2.4 percent and required the Secretary to develop a composite rate that includes, to the maximum extent feasible, payment for clinical diagnostic laboratory tests and drugs that are routinely used in dialysis treatments but are currently separately billable by dialysis facilities.

Report:

A-14-90-00215 (Final management advisory report, July 1990)

REDUCE THE EPOGEN REIMBURSEMENT RATE

Current Law:

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

Proposal:

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

Legislative	Regulatory	Other Administrative
✓	✓	

Reason for Action:

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

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$94	$94	$94	$94	$94

Status:

The Benefits Improvement and Protection Act increased the payment rate for services provided in 2001 by 2.4 percent and required the Secretary to develop a composite rate that includes, to the maximum extent feasible, payment for clinical diagnostic laboratory tests and drugs (including Epogen) that are routinely used in dialysis treatments but are currently separately billable by dialysis facilities.

Report

A-01-97-00509 (Final report, Nov. 1997)

ENSURE THAT CLAIMS FOR AMBULANCE SERVICES FOR END STAGE RENAL DISEASE BENEFICIARIES MEET COVERAGE GUIDELINES

Current Law:

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

Proposal:

The CMS should ensure that claims meet Medicare coverage guidelines.

Legislative	Regulatory	Other Administrative
☐	☐	✓

Reason for Action:

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

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$90	$99	$100	$101	$102

Status:

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

Report:

OEI-03-90-02130 (Final report, Aug. 1994)

MODIFY PAYMENT SYSTEM FOR AMBULANCE SERVICES FOR END STAGE RENAL DISEASE BENEFICIARIES

Current Law:

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

Proposal:

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

Legislative	Regulatory	Other Administrative
✓	✓	

Reason for Action:

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

Savings (in millions):

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

Status:

The CMS established codes for scheduled transport and required uniform use of national ambulance codes but did not modify the payment method. In June 1997, CMS issued a notice of proposed rulemaking which would require physician certification of nonemergency transports. The Balanced Budget Act of 1997 authorized the establishment of a fee schedule for ambulance services which links payments to the type of services provided.

Report:

OEI-03-90-02131 (Final report, Mar. 1994)

PREVENT MEDICARE LOSSES RESULTING FROM EARLY PAYMENTS FOR MEDICAL EQUIPMENT

Current Law:

Medicare covers DME, prosthetics, orthotics, and supplies under Medicare Part B. Medicare allowed approximately $6 billion for these claims in 1998.

Proposal:

We recommend that CMS not pay for DME, prosthetics, orthotics, and supply claims before the service period has been completed.

Legislative	Regulatory	Other Administrative
☐	☑	☐

Reason for Action:

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

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$7.2	$7.2	$7.2	$7.2	$7.2

Status:

The CMS did not concur with our recommendation**.**

Report:

OEI-03-99-00620 (Final report, June 2000)

LIMIT MEDICARE PART B REIMBURSEMENT FOR HOSPITAL BEDS

Current Law:

Medicare Part B covers the rental of medically necessary hospital beds used in the home when prescribed by a physician. Monthly rental payments are 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 15-month period.

Proposal:

The CMS should take immediate steps to reduce Medicare payments for hospital beds used in the home. This should include the elimination of the higher reimbursement rate currently paid during the first 3 months of rental.

Legislative	Regulatory	Other Administrative
✓		✓

Reason for Action:

Our reviews found that Medicare payments for hospital beds used in the home were substantially higher than rates paid by other payers. In addition, Medicare was the only payer we sampled that pays a higher reimbursement rate for the initial rental months. Based on work we did in Texas in 1989, we also estimate that suppliers can recover the wholesale cost of a bed within 4 months and as many as 7.5 times over the useful life of the bed.

Savings (in millions):

	FY 1	FY 2	FY 3	FY 4	FY 5
Inherent reasonable reduction	$40	$40	$40	$40	$40
Elimination of higher rate	$15	$15	$15	$15	$15

Note: These savings are not additive.

Status:

The CMS concurred with our recommendations and is considering options to determine the best approach to achieve a fair price for hospital beds. The agency is examining payment allowances and methodologies at other payers and is reviewing data to determine if Medicare payments are excessive. However, the Balanced Budget Refinement Act of 1999 imposed a moratorium on the application of CMS "inherent reasonableness" authority. Thus, while the moratorium is in place, CMS may not act on a determination that payments are excessive. The Benefits Improvement and Protection Act increased payments for DME by 3.7 percent for 2001.

Report:

A-06-91-00080 (Final report, May 1993)
OEI-07-96-00221 (Final report, Nov. 1998)
OEI-07-96-00222 (Final report, Nov. 1998)

REDUCE PAYMENTS FOR PRESSURE SUPPORT SURFACES

Current Law:

DME provided in a beneficiary's residence is generally billed to Medicare Part B. This equipment includes pressure-reducing support surfaces used for the care of decubitus ulcers or pressure sores. The CMS processes equipment claims through DME regional carriers. Effective January 1, 1996, regional carrier guidelines were developed to control medically unnecessary Medicare reimbursement for support surfaces.

Proposal:

The CMS should require periodic review and renewal of the certificate of medical necessity for beneficiaries' use of group 2 support surface equipment.

Legislative	Regulatory	Other Administrative
☐	☐	✓

Reason for Action:

While the 1996 guidelines appear to be having a positive impact on controlling Medicare costs for support surfaces, inappropriate payments are still noted. In 1996, 29 percent of beneficiaries sampled used support surfaces that were medically unnecessary, compared with 47 percent in 1995.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$12	$12	$12	$12	$12

Status:

The CMS did not agree with our recommendation and expressed concern about the timeliness and costs associated with using a certificate of medical necessity for group 2 equipment.

Report:

OEI-02-95-00370 (Final report, June 1997)

REVISE GUIDELINES FOR CODING ORTHOTIC BODY JACKETS

Current Law:

Body jackets are spinal orthotic devices that are covered by Medicare when prescribed by a physician. Code L0430 is defined as a custom-fitted, one-piece, molded plastic body jacket with interface material and an anterior or posterior opening.

Proposal:

The CMS should review and revise the Medicare coding guidelines for orthotic jackets and require suppliers to include more information on their Medicare claims. Specifically, CMS should use a product classification list to define exactly which products should be billed under code L0430.

Legislative	Regulatory	Other Administrative
☐	☐	☑

Reason for Action:

We found that suppliers upcoded 42 percent of L0430 body jacket claims in 1996. Lack of uniformity and standardization in the Medicare guidelines may account for some upcoding.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$0.8	$0.8	$0.8	$0.8	$0.8

Status:

The CMS agreed that a product classification list is an effective tool to define exactly which products should be billed under code L0430 but did not agree with our recommendation to revise Medicare coding guidelines.

Report:

OEI-04-97-00390 (Final report, Sept. 1999)

REDUCE ALLOWED CHARGES FOR ORTHOTIC BODY JACKETS

Current Law:

Body jackets are spinal orthotic devices that are covered by Medicare when prescribed by a physician. Code L0430 is defined as a custom-fitted, one-piece, molded plastic body jacket with interface material and an anterior or posterior opening.

Proposal:

The CMS should determine the appropriateness of Medicare-allowed charges for orthotic body jackets and adjust Medicare reimbursement accordingly.

Legislative	Regulatory	Other Administrative
☐	☐	☑

Reason for Action:

We found that Medicare often paid more for orthotic body jackets than did Medicaid or Tricare (the health care program for active duty and retired members of the uniformed services, their families, and survivors). We also found that Medicare reimbursement rates greatly exceeded the prices that suppliers paid for orthotic body jackets.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$0.22-$0.77	$0.22-$0.77	$0.22-$0.77	$0.22-$0.77	$0.22-$0.77

Status:

The CMS agreed to review Medicare-allowed amounts for orthotic body jackets once new final regulations on inherent reasonableness have been published.

Report:

OEI-04-97-00391 (Final report, Mar. 2000)

IMPROVE BILLING PRACTICES FOR MEDICARE ORTHOTICS

Current Law:

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

Proposal:

The CMS should improve Medicare billing for orthotics, including development of standards required for suppliers of custom molded/fabricated devices.

Legislative	Regulatory	Other Administrative
☐	☐	☑

Reason for Action:

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

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$43	$43	$43	$43	$43

Status:

Although CMS concurred with our original recommendations, problems continue.

Report:

OEI-02-95-00380 (Final report, Oct. 1997)
OEI-02-99-00120 (Final report, Mar. 2000)
OEI-02-99-00121 (Final report, Mar. 2000)

IMPROVE GUIDELINES FOR THERAPEUTIC FOOTWEAR

Current Law:

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

Proposal:

The CMS should make Medicare coverage guidelines more explicit and improve documentation requirements for therapeutic footwear. The CMS should also ensure that the therapeutic footwear benefit contains quality assurance safeguards.

Legislative	Regulatory	Other Administrative
☐	☐	☑

Reason for Action:

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

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$7	$7	$7	$7	$7

Status:

The CMS concurred with our recommendations and released a program memorandum in November 2001 requiring suppliers to indicate actual, accurate "start" and "end" dates on claim forms. The computer edits to ensure compliance with this new requirement were expected to be implemented in April 2002.

Report:

OEI-03-97-00300 (Final report, Aug. 1998)

ELIMINATE INAPPROPRIATE BILLING FOR BLOOD GLUCOSE TEST STRIPS

Current Law:

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

Proposal:

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

Legislative	Regulatory	Other Administrative
☐	☐	☑

Reason for Action:

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

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$79	$79	$79	$79	$79

Status:

The CMS concurred with our recommendations.

Report:

OEI-03-98-00230 (Final report, June 2000)

EXAMINE PAYMENT METHOD FOR PARENTERAL NUTRITION

Current Law:

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

Proposal:

The CMS should examine other payment methods that could lead to more cost-effective reimbursement for parenteral nutrition solutions. We suggest three alternative payment methods: (1) inherent reasonableness, (2) acquisition cost, and (3) competitive bidding.

Legislative	Regulatory	Other Administrative
✓		✓

Reason for Action:

For four parenteral nutrition codes, Medicare pays an average of 45 percent more than Medicaid agencies and 78 percent more than Medicare risk health maintenance organizations.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$65	$65	$65	$65	$65

Status:

The Balanced Budget Act of 1997 enacted several provisions that would address our recommendation. Section 4316 authorized CMS to make "inherent reasonableness" adjustments up to 15 percent for all Part B services other than physician services. However, the Balanced Budget Refinement Act of 1999 imposed a moratorium on the application of this authority. While the moratorium is in place, CMS may neither make a determination that payments are excessive nor establish new rates. Also, section 4319 of the 1997 act authorized up to five competitive bidding demonstrations. The CMS convened a workgroup to focus on ways to reduce costs for parenteral nutrition. While there is a statutory freeze on payment updates for 2001 and 2002, the President's FY 2001 budget proposed reducing the payment updates for parenteral and enteral items from 2003 through 2005.

Report:

OEI-03-96-00230 (Final report, July 1997)

REDUCE AND CONTROL ENTERAL NUTRITION EQUIPMENT COSTS

Current Law:

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

Proposal:

The DME regional carriers should consider selecting claims for special formulas, pump equipment, and/or pump supply kits when they determine target areas for focused medical reviews.

Legislative	Regulatory	Other Administrative
☐	☐	✓

Reason for Action:

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

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$28	$28	$28	$28	$28

Status:

The CMS agreed with our recommendation. The Balanced Budget Refinement Act of 1999 imposed a moratorium on the application of the "inherent reasonableness" adjustments authorized by the Balanced Budget Act of 1997. While the moratorium is in place, CMS may neither make a determination that payments are excessive nor establish new rates. In addition, there is a statutory freeze on payment updates for 2001 and 2002.

Report:

OEI-03-94-00022 (Final report, June 1997)

REDUCE MEDICARE PART B PAYMENTS FOR ENTERAL NUTRITION AT HOME

Current Law:

Enteral nutrition therapy is covered under Medicare Part B as a prosthetic benefit, limited to patients unable to eat normally who require enteral therapy as their primary source of nutrition. While the majority of payments are for patients in nursing homes, some patients receive enteral therapy as part of home care.

Proposal:

The CMS should reduce payments through competitive acquisition strategies for patients receiving enteral nutrition at home.

Legislative	Regulatory	Other Administrative
✓		✓

Reason for Action:

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

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$15	$15	$15	$15	$15

Status:

The CMS concurred that Medicare paid too much for enteral nutrients and supported the recommendation to reduce payments for enteral therapy administered at home. Included in section 4552(a) of the Balanced Budget Act of 1997 was a provision to freeze Medicare payments for parenteral and enteral nutrition, equipment, and supplies for 1998 through 2002. The DME regional carriers proposed additional payment reductions through their inherent reasonableness authority. The President's FY 2001 budget proposed reducing the payment updates for parenteral and enteral items from 2003 through 2005.

Report:

OEI-03-94-00021 (Final report, Apr. 1996)

IMPROVE MEDICAL REVIEWS FOR HOME OXYGEN THERAPY

Current Law:

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

Proposal:

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

Legislative	Regulatory	Other Administrative
☐	✓	☐

Reason for Action:

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

Savings (in millions):

	FY 1	FY 2	FY 3	FY 4	FY 5
Certificates	$263.0	$263.0	$263.0	$263.0	$263.0
Portable systems	9.7	9.7	9.7	9.7	9.7

Status:

The CMS concurred with our recommendations and formed a regulation team to develop proposed standards for suppliers of home oxygen equipment.

Report:

OEI-03-96-00090 (Final report, Aug. 1999)

STOP INAPPROPRIATE PAYMENTS FOR HYPERBARIC OXYGEN THERAPY

Current Law:

Hyperbaric oxygen therapy (HBO2) was originally developed for the treatment of decompression sickness, but its primary use in the United States is for wound care. The CMS Coverage Instruction Manual, section 35-10, establishes 14 conditions for which hyperbaric therapy is reimbursable.

Proposal:

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

Legislative	Regulatory	Other Administrative
☐	☐	✓

Reason for Action:

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

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$19.1	$19.1	$19.1	$19.1	$19.1

Status:

The CMS generally concurred with our recommendations and reported several ongoing efforts to address our concerns.

Report:

OEI-06-99-00090 (Final report, Oct. 2000)

MODIFY PAYMENTS TO MANAGED CARE ORGANIZATIONS

Current Law:

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

Proposal:

The CMS should modify monthly capitation rates to a level fully supported by empirical data.

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

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

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$3,500	$3,500	$3,500	$3,500	$3,500

Status:

The CMS agreed that Medicare+Choice payments were adequate to fund the Medicare package of covered services. Agency officials stated that they would move toward full implementation of a risk adjustment methodology incorporating diagnosis data from physician services and hospital outpatient services. Subsequently, the Benefits Improvement and Protection Act of 2000 increased payments to MCOs. In addition, implementation of the risk adjustment methodology was extended over a longer period.

Report:

A-14-00-00212 (Final report, Sept. 2000)

PAY MANAGED CARE ORGANIZATIONS ONLY REASONABLE ADMINISTRATIVE COSTS

Current Law:

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

Proposal:

The CMS should pursue legislation to require risk-based MCOs, when estimating administrative costs, to follow Medicare's general principle of paying only reasonable costs. The CMS should also publish the administrative cost rates of all MCOs participating in the Medicare program.

Legislative	Regulatory	Other Administrative
✓		✓

Reason for Action:

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

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

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
TBD	TBD	TBD	TBD	TBD

Status:

The CMS did not agree with our recommendations.

Report:

A-03-98-00046 (Final report, Jan. 2000)

PLACE A CEILING ON ADMINISTRATIVE COSTS INCLUDED IN MANAGED CARE ORGANIZATIONS' RATE PROPOSALS

Current Law:

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

Proposal:

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

Legislative	Regulatory	Other Administrative
✓		✓

Reason for Action:

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

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
TBD	TBD	TBD	TBD	TBD

Status:

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

Report:

A-14-98-00210 (Final report, Jan. 2000)

MONITOR INVESTMENT INCOME EARNED BY RISK-BASED MANAGED CARE ORGANIZATIONS

Current Law:

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

Proposal:

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

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

There is no present requirement for MCOs with risk contracts to account for investment income. Investment income is earned from the time MCOs receive payment from CMS until these funds are disbursed to providers. We found that MCOs earned in excess of $100 million a year on current-year Medicare funding during 1996 and 1997 and continued to earn significant amounts of investment income in 1998. On average, plans earned an estimated 5-percent return from short-term investments of Medicare prepayment funding. As a result, we are concerned that MCOs were effectively funded at a greater amount (approximately 0.4 percent more) than the 95 percent of Medicare fee-for-service costs used as a basis for calculating MCO payment rates.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$150	$150	$150	$150	$150

Status:

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

Report:

A-02-98-01005 (Final report, Aug. 2000)

MONITOR PAYMENTS FOR END STAGE RENAL DISEASE BENEFICIARIES IN MANAGED CARE PLANS

Current Law:

Under the Medicare managed care risk program, CMS contracts with MCOs to provide comprehensive health services to enrolled beneficiaries on a prepayment, capitated basis. For each enrolled beneficiary, CMS authorizes a fixed monthly payment which is adjusted by a set of risk factors, such as the beneficiary's age and gender. An enhanced payment is made for certain high-cost categories of beneficiaries, such as those having ESRD. The monthly payment for an ESRD beneficiary (average of $3,393 per month) is approximately seven times greater than the regular non-ESRD payment rate (average of $460 per month).

Proposal:

The CMS should make procedural and systems changes to prevent further erroneous misclassifications of ESRD status and instruct all ESRD networks to verify the status of beneficiaries and to submit census data on a timely basis.

Legislative	Regulatory	Other Administrative
☐	☐	✓

Reason for Action:

Our review of beneficiary Medicare records and information obtained from the CMS Renal Beneficiary and Utilization System found that 18 percent of the beneficiaries reviewed were ESRD-misclassified during 1997, resulting in $112,486 in gross payment errors. We believe that these errors occurred because CMS received incomplete data from ESRD networks concerning the eligibility status of ESRD beneficiaries. As a result, we are concerned that these errors could affect the risk-adjusted payments that were implemented in January 2000 by a revision in the Balanced Budget Act of 1997.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
TBD	TBD	TBD	TBD	TBD

Status:

The CMS agreed with all of our recommendations. Currently, CMS has information management projects underway that are focused on improved business processes within the ESRD program and better data management.

Report:

A-14-98-00211 (Final report, July 2000)

PREVENT PAYMENTS TO MANAGED CARE PLANS FOR DECEASED BENEFICIARIES

Current Law:

Enrollment in MCOs becomes effective on the first day of the month. Under Medicare risk-based contracts, MCOs receive a capitated payment every month for each of their Medicare enrollees. When an enrollee dies, the disenrollment becomes effective on the first day of the month immediately following death. Thus, the final Medicare payment to the MCO should be for the month in which the beneficiary died.

Proposal:

The CMS should make immediate corrections to its computer system to prevent payments to MCOs for deceased beneficiaries. It should also recover the improper capitation payments that were paid to the MCOs for deceased beneficiaries.

Legislative	Regulatory	Other Administrative
☐	☐	✓

Reason for Action:

The CMS paid $4.2 million in capitated payments to MCOs after beneficiaries died. Although CMS recouped $1.2 million of the improper payments, $3 million remained outstanding because CMS was unaware of the deaths and did not act to collect some identified overpayments. The improper payments started as early as January 1993 and continued through June 1999. In addition, CMS continued to pay at least $1.3 million a year for deceased beneficiaries.

Our later review found that CMS paid MCOs $4.1 million in capitated payments for deceased beneficiaries through at least October 2000. The CMS recouped only $0.8 million of these improper payments, leaving over $3.2 million outstanding. In addition, CMS continued to pay at least $700,000 a year for the beneficiaries identified in our review.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$3	$1.3	$1.3	$1.3	$1.3

Status:

The CMS stated that it was aware that payments were being made to MCOs for deceased beneficiaries and made system corrections in mid-1998 to address the problem. The CMS agreed to investigate and collect, if appropriate, any OIG-identified overpayments for deceased beneficiaries.

Report:

A-07-99-01283 (Final report, Feb. 2000)
A-07-99-01298 (Final report, May 2001)

ELIMINATE MEDICARE PAYMENTS FOR SERVICES AFTER DEATH

Current Law:

Medicare's Common Working File host sites receive daily updated beneficiary information, including date of death, from the CMS enrollment database, which receives daily data from the Social Security Administration and the Railroad Retirement Board. In addition, the Common Working File receives some date-of-death information directly from institutional claims submitted by intermediaries.

Proposal:

The CMS should require Medicare contractors to conduct annual postpayment reviews to identify and recover payments for services after death.

Legislative	Regulatory	Other Administrative
☐	☐	✓

Reason for Action:

Medicare paid $20.6 million in 1997 for services that started after beneficiaries' death. Further, we found that Medicare did not have uniform postpayment procedures to identify and recover payments for deceased beneficiaries.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$20.6	$20.6	$20.6	$20.6	$20.6

Status:

The CMS concurred with our recommendations and took a number of actions to correct the deficiencies identified in the report. In addition to providing special funding for contractors to identify and recover improper payments, CMS planned to issue instructions for FY 2001, requiring all Medicare contractors to perform these reviews.

Report:

OEI-03-99-00200 (Final report, Mar. 2000)

CHANGE THE WAY MEDICARE PAYS FOR CLINICAL LABORATORY TESTS

Current Law:

The amount that Medicare pays for most clinical lab tests is based on fee schedules. These schedules, effective July 1, 1984, generally were established by each carrier at 60 percent of the Medicare prevailing charge (the charge most frequently used by all suppliers). The Balanced Budget Act of 1997 reduced fee schedule payments by lowering the cap to 74 percent of the median for payment amounts beginning in 1998. Also, no inflation update was permitted between 1998 and 2002.

Proposal:

The CMS should (1) develop a methodology and legislative proposal to pay for tests ordered as custom panels at substantially less than the full price for individual tests and (2) study reinstating the beneficiary coinsurance and deductible provisions for laboratory services as a means of controlling utilization.

Legislative	Regulatory	Other Administrative
✓		✓

Reason for Action:

Although prices on individual tests are being reduced by legislation, panels are still generally being billed as individual tests. Medicare policies are not sufficient to control the billing of profile tests because there is no requirement that the tests ordered as a panel by the physician be billed only as a panel. The CMS guidelines do not address the problem of panels as a marketing mechanism of the laboratory industry or the problem of industry billing for the contents of the panels individually. In our opinion, these conditions have contributed to the significant increase in the use of laboratory services.

Savings (in millions):

	FY 1	FY 2	FY 3	FY 4	FY 5
Panel	TBD	TBD	TBD	TBD	TBD
Copayment	$1,130	$1,240	$1,370	$1,520	$1,690

Status:

The CMS initially concurred with our first recommendation but not our second. A proposal to reduce payment updates from 2003 through 2005 was included in the President's FY 2001 budget, as well as a proposal to reinstate laboratory cost sharing. Neither of these proposals was enacted. In addition, the Balanced Budget Act of 1997 required the Secretary to contract with the Institute of Medicine for a study of Part B laboratory test payments; CMS may use the results to develop new payment methodologies.

Report:

A-09-89-00031 (Final report, Jan. 1990)
A-09-93-00056 (Follow-up report, Jan. 1996)

PREVENT INAPPROPRIATE MEDICARE PAYMENTS FOR CLINICAL LABORATORY TESTS

Current Law:

Clinical laboratory services performed by independent laboratories, physicians, and hospital outpatient department laboratories include chemistry, hematology, and urinalysis tests. The Medicare carrier and fiscal intermediary manuals refer to tests that can be and are frequently performed together on automated multichannel equipment as panels. Carriers are directed to pay the lesser panel amount if the sum of the payment allowance for the separately billed tests exceeds the payment allowance for the panel that includes these tests. For claims submitted by hospital outpatient department laboratories, fiscal intermediaries are required to apply the carrier fee schedule and to follow the practices in effect for the carrier's locality.

Proposal:

The CMS should direct carriers and intermediaries to (1) implement procedures and controls to ensure that clinical laboratory tests are appropriately grouped together and not duplicated for payment purposes and (2) recover potential overpayments from providers. The CMS should also consider eliminating separate reimbursement for additional indices on the basis that they are a byproduct of analyses performed on automated equipment.

Legislative	Regulatory	Other Administrative
☐	☐	✓

Reason for Action:

Medicare carriers and fiscal intermediaries did not always have adequate controls to detect and prevent inappropriate payments for laboratory tests. Contrary to applicable laws, regulations, and Medicare reimbursement policies, carriers and intermediaries reimbursed providers for claims involving (1) unbundled and/or duplicate chemistry, hematology, and urinalysis tests that should have been grouped together and paid at a lesser amount and (2) additional indices that were not ordered, received, or needed by a physician.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$12.5	$12.5	$12.5	$12.5	$12.5

Status:

The CMS concurred with all recommendations. The CMS also agreed to institute new coding procedures and will remove codes for additional indices from Medicare fee schedules. As of 1999, two codes for indices were removed from the physicians' current procedural terminology.

Report:

A-01-96-00509 (Final report, Nov. 1997)
A-01-96-00527 (Final report, Nov. 1998)
A-01-99-00522 (Final report, Oct. 2000)

ELIMINATE VULNERABILITIES TO MEDICARE FROM INDEPENDENT DIAGNOSTIC TESTING FACILITIES

Current Law:

Independent physiological laboratories (IPLs) operate independently of a hospital, physician's office, or rural health clinic. IPL testing modalities include neurological and neuromuscular tests, echocardiograms, ultrasounds, x-rays, pulmonary function tests, cardiac monitoring, and nuclear medicine. New regulations affecting IPLs (now designated independent diagnostic testing facilities, or IDTFs) went into effect January 1, 1998.

Proposal:

The CMS should more clearly define the term "operating independent," establish a more stringent enrollment and verification process, and strengthen monitoring and control processes. As an option, CMS could completely reform the payment system by eliminating direct payment to IPLs/IDTFs.

Legislative	Regulatory	Other Administrative
☐	☐	✓

Reason for Action:

Based on our sample, nearly 1,000 of the 5,000 provider numbers issued to IPLs may have been issued to entities that no longer exist. We estimated that Medicare could have paid about $11.6 million in 1996 to such entities. We also noted that a number of IPLs in our sample were owned by hospitals, physicians, or rural health clinics that did not consider their IPLs to be "operating independent" as the services provided were principally for their own patients.

Savings (in millions):*

FY 1	FY 2	FY 3	FY 4	FY 5
$11.6	$11.6	$11.6	$11.6	$11.6

** Possible payments to IPLs that do not exist.*

Status:

The CMS has site-visited and desk-reviewed all existing IDTFs and has verified all information that these entities provided on their required Provider Enrollment Forms. This includes information concerning their qualifications. The CMS is also in the process of revising these forms. The revision, coupled with corresponding updated Medicare contractor operating manual provisions, will aid in determining what qualifies as an IDTF.

Report:

OEI-05-97-00240 (Final report, Aug. 1998)
OEI-05-97-00241 (Final report, Aug. 1998)

REQUIRE PHYSICIAN EXAMINATION BEFORE ORDERING HOME HEALTH SERVICES

Current Law:

Section 1861 of Title XVIII of the Social Security Act authorized Medicare Part A payments for home health services. Before October 1, 2000, when the prospective payment system for home health services was implemented, providers were reimbursed for the cost of each visit up to limits established by the Department. Home health agencies are now reimbursed under the prospective payment system.

Proposal:

Medicare regulations should be revised to require physicians to examine patients before ordering home health care. As discussed under "Status," other recommendations to correct abusive and wasteful practices are being addressed.

Legislative	Regulatory	Other Administrative
☐	✓	☐

Reason for Action:

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

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
TBD	TBD	TBD	TBD	TBD

Status:

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

Report:

A-04-94-02078 (Final report, Feb. 1995)
A-04-94-02087 (Final report, June 1995)
A-04-95-01103 (Final report, Mar. 1996)
A-04-95-01106 (Final report, Mar. 1996)
A-04-95-01104 (Final report, June 1996)
A-04-95-01105 (Final report, Sept. 1996)
A-04-95-01107 (Final report, Sept. 1996)
A-03-95-00011 (Final report, Nov. 1996)
A-04-96-02121 (Final report, July 1997)
A-02-97-01026 (Final report, Sept. 1997)
A-04-97-01166 (Final report, Apr. 1999)
A-04-97-01169 (Final report, Apr. 1999)
A-04-97-01170 (Final report, Apr. 1999)
A-02-97-01034 (Final report, Sept. 1999)
A-04-98-01184 (Final report, Sept. 1999)
A-04-99-01194 (Final report, Nov. 1999)
A-04-99-01195 (Final report, Mar. 2001)
OEI-12-94-00180 (Final report, May 1995)
OEI-02-94-00170 (Final report, June 1995)
OEI-04-93-00260 (Final report, July 1995)
OEI-04-93-00262 (Final report, Sept. 1995)

ENSURE VALIDITY OF MEDICARE HOSPICE ENROLLMENTS

Current Law:

Hospice care is a treatment approach which recognizes that the impending death of an individual warrants a change in focus from therapeutic to palliative care (such as pain control and symptom management). To qualify for Medicare hospice benefits, which began in 1983, a patient must be entitled to Medicare Part A and be certified as terminally ill, which is defined as having a life expectancy of 6 months or less if the illness runs its normal course.

Proposal:

The CMS should strengthen its controls over the hospice program, such as by reinforcing the 6-month terminal prognosis requirement, holding hospice physicians more accountable for certifications of terminal prognosis, strengthening claim processing controls, and prohibiting hospices from paying nursing facilities more for "room and board" than the hospices receive from State Medicaid agencies on behalf of dually eligible beneficiaries. The CMS should also seek legislation to change the payment methodology for dually eligible nursing facility residents, to restructure the use of benefit periods, and to establish a more meaningful cap on hospice payments.

Legislative	Regulatory	Other Administrative
✓		✓

Reason for Action:

Our audits of 12 large hospices identified a substantial number of ineligible enrollments. Working with OIG, physicians from Medicare peer review organizations reviewed the medical files of 2,109 long-term beneficiaries in hospice care over 210 days and concluded that 1,373 beneficiaries were ineligible because they were not terminally ill. Also, analysis of the CMS database for hospice beneficiaries showed evidence of many long-term beneficiaries in other hospices across the country.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
TBD	TBD	TBD	TBD	TBD

Status:

The Balanced Budget Act of 1997 modified the hospice benefit but did not address the above recommendations. The CMS has increased its scrutiny of hospice claims by subjecting an increased number of claims to medical review. Also, the Benefits Improvement and Protection Act of 2000 clarified that certification regarding terminal illness is to be based on the physician's clinical judgment, and CMS informed providers of this clarification. No changes have been proposed to modify the payment methodology for dually eligible nursing facility residents. The President's FY 2001 budget proposed civil monetary penalties for false certification of the need for hospice care.

Report:

A-05-96-00023 (Final report, Nov. 1997)
OEI-05-95-00250 (Final report, Sept. 1997)
OEI-05-95-00251 (Final report, Nov. 1997)

ADJUST BASE-YEAR COSTS IN THE PROSPECTIVE PAYMENT SYSTEM FOR SKILLED NURSING FACILITIES

Current Law:

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

Proposal:

The CMS should determine the costs of unnecessary services and other improper payments and eliminate them from the prospective payment system rates for skilled nursing facilities.

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

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

Savings (in millions):

	FY 1	FY 2	FY 3	FY 4	FY 5
Physical and occupational therapy	$1,000+	$1,000+	$1,000+	$1,000+	$1,000+
All other	TBD	TBD	TBD	TBD	TBD

Status:

The CMS agreed with our recommendation and indicated in its interim final rule implementing the prospective payment system that OIG, in conjunction with CMS, proposed to further examine the extent to which the base-year cost data used to develop the rates included costs that were inappropriately allowed. We subsequently advised CMS of the significant problems found during our review of infusion therapy services provided by some suppliers to skilled nursing facilities and recommended that CMS consider our findings when updating or refining the payment rates. The CMS concurred.

Report:

A-14-98-00350 (Final report, July 1998)
A-06-99-00058 (Final report, Dec. 1999)
OEI-09-97-00122 (Final report, Nov. 2000)

ELIMINATE OVERPAYMENTS UNDER CONSOLIDATED BILLING BY SKILLED NURSING FACILITIES

Current Law:

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

Proposal:

The CMS should establish payment edits in its Common Working File and Medicare contractors' claim processing systems to ensure compliance with consolidated billing requirements.

Legislative	Regulatory	Other Administrative
☐	☐	☑

Reason for Action:

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

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$47.6	$47.6	$47.6	$47.6	$47.6

Status:

The CMS concurred with our recommendation and expected to implement edits in the spring of 2002. Until the edits are in place, we will continue our work to identify additional overpayments.

Report:

A-01-99-00531 (Final report, Mar. 2000)
A-01-00-00538 (Final report, June 2001)

CONDUCT MEDICAL REVIEWS OF PART B THERAPY SERVICES

Current Law:

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

Proposal:

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

Legislative	Regulatory	Other Administrative
☐	☐	✓

Reason for Action:

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

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$97	$97	$97	$97	$97

Status:

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

Report:

OEI-09-97-00122 (Final report, Aug. 1999)
OEI-09-99-00550 (Final report, Nov. 2000)
OEI-09-99-00560 (Final report, Aug. 2001)

REVISE MEDICARE PRESCRIPTION DRUG PAYMENT METHODS

Current Law:

Medicare Part B covers prescription drugs incident to a physician's services for drugs that cannot be self-administered; for certain medical disorders, such as end stage renal disease and cancer; and when necessary for the effective use of DME. Reimbursement is based on the lower of estimated actual charges or a national AWP less 5 percent.

Proposal:

The CMS should reduce excessive Medicare drug reimbursement amounts.

Legislative	Regulatory	Other Administrative
✓	✓	✓

Reason for Action:

Several OIG reports demonstrate that Medicare and its beneficiaries are making excessive payments for prescription drugs. The published AWPs currently used by Medicare carriers to determine reimbursement bear little or no resemblance to actual wholesale prices available to the physician and supplier communities that bill for these drugs. Our most recent report found that Medicare and its beneficiaries could have saved $1.6 billion a year if 24 drugs had been reimbursed at amounts available to the Department of Veterans Affairs. We also found that Medicare carriers did not establish consistent reimbursement amounts for certain drugs.

Savings (in millions):*

FY 1	FY 2	FY 3	FY 4	FY 5
$1,600	$1,600	$1,600	$1,600	$1,600

**Includes beneficiary copayment amounts.*

Status:

The CMS concurred with our recommendation. The agency has attempted administrative remedies to lower payments for albuterol sulfate by using "inherent reasonableness," but the Congress suspended use of this authority pending the issuance of Federal rulemaking. The CMS also announced plans to lower prices for certain drugs using newly available AWPs developed for Medicaid as a result of Department of Justice investigations. However, legislation passed on December 21, 2000, requires the General Accounting Office to complete a comprehensive drug pricing study before CMS can begin using these new data.

Report:

OEI-03-94-00390 (Final report, Mar. 1996)
OEI-03-95-00420 (Final report, May 1996)
OEI-03-97-00390 (Final report, July 1997)
OEI-03-97-00292 (Final report, Aug. 1998)
OEI-03-97-00293 (Final report, Nov. 1998)
OEI-03-00-00310 (Final report, Jan. 2001)

ALLOW PAYMENT FOR NONEMERGENCY ADVANCED LIFE SUPPORT AMBULANCE SERVICES ONLY WHEN MEDICALLY NECESSARY

Current Law:

The Social Security Act, section 1861(s)(7), provides for coverage of ambulance services when medically necessary. The limitations for this coverage, as specified in 42 CFR 410.40, include the requirement that the services be medically necessary, specifically that other means of transportation are contraindicated by the beneficiary's condition. However, because CMS does not make a coverage distinction between advanced life support and basic life support services, payments are based on the type of transportation furnished, not the level of service required by the beneficiary. Effective March 1, 1982, CMS allowed separate reimbursement rates for advanced and basic life support ambulances.

Proposal:

The CMS should modify its Medicare policy to allow payment for nonemergency advanced life support services only when that level of service is medically necessary, instruct carriers to institute controls to ensure that payment is based on the medical need of the beneficiary, and closely monitor carrier compliance.

Legislative	Regulatory	Other Administrative
☐	✓	☐

Reason for Action:

For CY 1986-1989, the number of trips by Medicare beneficiaries in advanced life support ambulances increased by 131 percent, while the number of trips in basic life support ambulances increased by only 14 percent. Of a sample of 400 claims in 1989, 18 percent were for services not medically necessary at the advanced level and were reimbursed at the advanced level even though basic life support services were available in the same city or town.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$47	$47	$47	$47	$47

Status:

The Balanced Budget Act of 1997 required that CMS link payments to services provided and that the definitions of basic life support and advanced life support ambulance services be subject to negotiated rulemaking. The Negotiated Rulemaking Committee Statement on the Medicare Ambulance Services Fee Schedule was signed in February 2000. The CMS published the final rule in the Federal Register in February 2002.

Report:

A-01-91-00513 (Final report, Oct. 1992)
A-01-94-00528 (Final report, June 1995)

ENSURE THE MEDICAL NECESSITY OF AMBULANCE CLAIMS

Current Law:

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

Proposal:

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

Legislative	Regulatory	Other Administrative
☐	☐	✓

Reason for Action:

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

Savings (in millions):*

FY 1	FY 2	FY 3	FY 4	FY 5
$104	$104	$104	$104	$104

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

Status:

The CMS has completed negotiated rulemaking on development of the Medicare ambulance fee schedule and is in the process of proposing regulations. The fee schedule was to take effect in April 2002. The CMS contracted for a study related to nonemergency ambulance transportation and is currently reviewing the results to determine the appropriate actions to take in light of the new fee schedule and the codes associated with the schedule. As the new codes are established, CMS intends to explore appropriate edits.

Report:

OEI-09-95-00412 (Final report, Dec. 1998)

STOP INAPPROPRIATE PAYMENTS FOR CHIROPRACTIC MAINTENANCE TREATMENTS

Current Law:

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

Proposal:

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

Legislative	Regulatory	Other Administrative
☐	☐	✓

Reason for Action:

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

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$78	$78	$78	$78	$78

Status:

Now that Y2K issues have been resolved, CMS plans to move forward with its efforts to require that all contractors establish systems utilization frequency edits and that chiropractic physicians use modifiers distinguishing the categories of spinal joint problems. In the interim, in some instances, contractors are reviewing chiropractic claims on a postpayment basis and are detecting maintenance therapy through data analysis.

Report:

OEI-06-97-00480 (Final report, Sept. 1998)
OEI-04-97-00490 (Final report, Nov. 1998)

ESTABLISH UTILIZATION PARAMETER FOR CHIROPRACTIC TREATMENTS

Current Law:

The Balanced Budget Act of 1997 required CMS to establish new utilization guidelines for Medicare chiropractic care. The CMS currently allows each carrier to establish its own utilization review parameter for chiropractic treatments.

Proposal:

The CMS should require carriers to use 12 services as a maximum review parameter. This parameter does not mean that payments for services above 12 should be disallowed, but rather it should trigger a more intensive review of claims to ensure that the billed services are necessary and covered. Once this parameter is implemented, CMS should collect data on the cost of administering it, related edits and frequency screens, and medical reviews with a view to finding the best mix of these controls and recalibrating them after 1 or 2 years of experience.

Legislative	Regulatory	Other Administrative
☐	☐	☑

Reason for Action:

We found that Medicare savings would be higher with a cap of 12 rather than 18 treatments per year. This is the number most commonly used by Medicare carriers; 29 of the 55 carriers already have chiropractic utilization parameters set at 12 treatments per year. Therefore, implementing a utilization parameter of 12 will result in the least administrative change for carriers overall.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$30.2	$32.3	$34.5	$36.9	$39.4

Status:

The CMS is currently developing utilization guidelines as specified in the Balanced Budget Act of 1997. It is using the information in our report to help determine the most appropriate utilization screen.

Report:

OEI-04-97-00496 (Final report, Nov. 1999)

DISCONTINUE USE OF A SEPARATE CARRIER TO PROCESS MEDICARE CLAIMS FOR RAILROAD RETIREMENT BENEFICIARIES

Current Law:

From the inception of the Medicare supplementary medical insurance program (Part B), claims for Railroad Retirement beneficiaries have been processed by a single carrier. This carrier, currently Palmetto Government Benefits Administrators, has a contract with the Railroad Retirement Board to process Medicare Part B claims for Railroad Retirement beneficiaries. All other Medicare carriers contract with CMS to process claims. The authority for this unique contracting arrangement is section 1842(g) of the Social Security Act, as amended.

Proposal:

The CMS should discontinue the use of a separate carrier to process Medicare claims for Railroad Retirement beneficiaries.

Legislative	Regulatory	Other Administrative
✓		

Reason for Action

Since 1979, the General Accounting Office, the Grace Commission, and CMS have recommended that Railroad Retirement beneficiaries be placed under the CMS carrier system. In following up on these recommendations, we found that cost savings of $9.1 million could be achieved by implementing the proposal. In addition, provider billings would be simplified since the service providers would no longer need to separate and submit Railroad Retirement claims for payment to the Railroad Retirement Board's carrier and other Medicare claims to a different carrier. A further benefit is that beneficiaries would be assured that their claims would be processed timely and not routed to the wrong carrier for payment, as has sometimes happened in the past.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$9.1	$9.1	$9.1	$9.1	$9.1

Status:

The President's FY 2002 and 2003 budgets did not include such a proposal.

Report:

A-14-90-02528 (Final report, Dec. 1990)

IMPROVE MEDICARE SECONDARY PAYER SAFEGUARDS

Current Law:

Medicare is the secondary payer to certain group health plans in instances where medical services were rendered to Medicare-entitled employees or to the Medicare-entitled spouses and other family members of employees. Medicare is also the secondary payer in situations involving coverage under Worker's Compensation; black lung benefits; automobile and nonautomobile, no fault, or liability insurance; and Department of Veterans Affairs programs. The CMS provides administrative funds to Medicare contractors to monitor and collect incorrect primary benefits paid on behalf of Medicare beneficiaries.

Proposal:

The CMS should (1) ensure that contractor resources are sufficient and instruct contractors to recover improper primary payments from insurance companies; (2) implement financial management systems to ensure that all overpayments (receivables) are accurately recorded; (3) develop detailed procedures to properly handle employers that refuse to provide other health insurance coverage information; and (4) resubmit justification of a legislative proposal to require insurance companies, underwriters, and third-party administrators to periodically submit private insurance coverage data directly to CMS.

Legislative	Regulatory	Other Administrative
✓		✓

Reason for Action:

Measures are needed to collect accurate and timely information on primary payers. This will help to reduce future Medicare overpayments that result from unidentified Medicare secondary payer cases and improve the recovery process for overpayments.

Savings (in millions):*

FY 1	FY 2	FY 3	FY 4	FY 5
$40	$190	$190	$190	$190

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

Status:

The CMS is pursuing the recommended administrative actions through improved processes to identify and recover Medicare secondary payer overpayments. In this regard, a coordination-of-benefits contract has been awarded. The President's FY 2001 budget proposed a requirement that insurance companies provide Medicare secondary payer information. The CMS is negotiating data-sharing agreements with several State workers' compensation boards. In addition, CMS has signed several voluntary reporting agreements with employers and insurers to exchange eligibility information and is negotiating agreements with other interested entities.

Report:

A-09-89-00100 (Final management advisory report, Mar. 1990)
OEI-07-90-00760 (Final report, Aug. 1991)
OEI-03-90-00763 (Management advisory report, Nov. 1991)
A-09-91-00103 (Final report, Aug. 1992)
A-14-94-00391 (Final report, Dec. 1993)
A-14-94-00392 (Final report, Mar. 1994)
A-02-98-01036 (Final report, July 2000)

EXPAND MEDICARE SECONDARY PAYER PROVISIONS FOR END STAGE RENAL DISEASE BENEFITS

Current Law:

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

Proposal:

The Medicare secondary payer provision should be extended to include ESRD beneficiaries without a time limitation.

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

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

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
TBD	TBD	TBD	TBD	TBD

Status:

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

Report:

A-10-86-62016 (Final report, Dec. 1987)

LIMIT MEDICAID REIMBURSEMENT FOR HIGHER PRICED GENERIC DRUGS TO THAT FOR LOWER PRICED BRAND NAME DRUGS

Current Law:

Each State Medicaid agency has the authority to develop its own reimbursement methodology for prescription drugs, subject to upper limits set by CMS. For the most part, State Medicaid agencies use either a discounted AWP or estimated/wholesale acquisition costs as the basis for calculating reimbursement for individual prescription drugs.

Proposal:

The CMS should limit Medicaid reimbursement for higher priced generic drugs to the amount reimbursed (prior to rebate) for lower priced brand name drugs or appropriately priced generic drugs.

Legislative	Regulatory	Other Administrative
☐	✓	✓

Reason for Action:

Currently, Medicaid reimburses certain generic prescription drugs at a higher level than lower priced brand name drugs. We found that one Medicaid agency would have saved half a million dollars for just eight drugs in 1996 if reimbursement had been limited to the lower priced brand name drugs. We estimate that the Medicaid program, as a whole, would have saved $7 million in 1996 for these eight drugs.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$7	$7	$7	$7	$7

Status:

The CMS did not concur with our recommendation. The agency agreed that high-priced drugs could adversely affect Medicaid reimbursement but believed that States already had the authority to institute programs to ensure appropriate prescription drug payments. However, we found that the current authorities provided to States did not prevent Medicaid from paying more for generic versions of drugs than for brand name products.

Report:

OEI-03-97-00510 (Final report, July 1998)

ESTABLISH CONNECTION BETWEEN THE CALCULATION OF MEDICAID DRUG REBATES AND DRUG REIMBURSEMENT

Current Law:

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

Proposal:

The CMS should seek legislation that would require drug manufacturers participating in the Medicaid outpatient prescription drug program to pay Medicaid drug rebates based on AWP or study other viable alternatives to the current program of using AMP to calculate the rebates.

Legislative	Regulatory	Other Administrative
✓		✓

Reason for Action:

Requiring manufacturers to pay Medicaid drug rebates based on AWP would (1) eliminate inconsistencies in the present methods used by drug manufacturers to calculate AMP; (2) establish a much-needed connection between the calculation of Medicaid drug rebates and the calculation of Medicaid reimbursement for drugs at the pharmacy level; and (3) reduce the burden of administering the Medicaid drug rebate program at the Federal, State, and manufacturer levels.

Savings (in millions):*

FY 1	FY 2	FY 3	FY 4	FY 5
TBD	TBD	TBD	TBD	TBD

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

Status:

The CMS agreed to pursue a change in the Medicaid drug rebate program similar to that recommended. The President's FY 2003 budget proposes a legislative change that would base the Medicaid drug rebate on the difference between AWP and the best price for a drug.

Report:

A-06-97-00052 (Final report, May 1998)

IMPLEMENT AN INDEXED BEST PRICE CALCULATION IN THE MEDICAID DRUG REBATE PROGRAM

Current Law:

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

Proposal:

The best price calculation in the Medicaid drug rebate program should be indexed.

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

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

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$123	$123	$123	$123	$123

Status:

The CMS continues to nonconcur with the recommendation. The agency believes that savings will be achieved through the President's budget proposal for a legislative change that would base the Medicaid drug rebate on the difference between AWP and the best price for a drug. We are continuing to monitor the drug rebate program; audits will continue to focus on enhancing the collection of rebates and providing potential savings to the rebate program.

Report:

A-06-94-00039 (Final report, Oct. 1995)

INSTALL EDITS TO PRECLUDE IMPROPER MEDICAID REIMBURSEMENT FOR CLINICAL LABORATORY SERVICES

Current Law:

Clinical diagnostic laboratory tests performed in a physician's office, by an independent laboratory, or by a hospital laboratory for outpatients are reimbursed on the basis of fee schedules. Medicaid reimbursement for these tests may not exceed the amount that Medicare recognizes, and each Medicare carrier in a State is to provide its fee schedule to the State agency. For purposes of the fee schedule, clinical diagnostic laboratory services include laboratory tests listed in codes 80002 - 89399 of the Current Procedural Terminology Manual. Federal matching funds are not available for any amount over the amount recognized by Medicare for such tests.

Proposal:

The State agencies should (1) install edits to detect and prevent payments that exceed the Medicare limits and billings that contain duplicative tests, (2) recover overpayments for clinical laboratory services identified in each of the reviews, and (3) make adjustments for the Federal share of the amounts recovered by the State agencies.

Legislative	Regulatory	Other Administrative
☐	☐	☑

Reason for Action:

State agencies reimbursed providers for laboratory services that exceeded the Medicare limits or were duplicatively billed. These overpayments occurred because the State agencies did not have adequate computer edits in place to prevent the payment of unbundled or duplicated claims for chemistry, hematology, or urinalysis tests.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$17.8	$17.8	$17.8	$17.8	$17.8

Status:

In January 1997, CMS alerted all State Medicaid directors to our findings, encouraged them to use Medicare bundling policies, and urged them to install appropriate payment edits in their claim processing systems. We are performing several follow-up reviews in this area and will update the status as these reviews progress.

Report:

A-07-95-01139 (Final report, Sept. 1995)
A-07-95-01147 (Final report, Oct. 1995)
A-06-95-00078 (Final report, Nov. 1995)
A-04-95-01108 (Final report, Dec. 1995)
A-06-96-00031 (Final report, Dec. 1995)
A-01-95-00005 (Final report, Jan. 1996)
A-01-96-00001 (Final report, Feb. 1996)
A-04-95-01113 (Final report, Feb. 1996)
A-05-95-00035 (Final report, Feb. 1996)
A-05-96-00019 (Final report, Mar. 1996)
A-07-95-01138 (Final report, Mar. 1996)
A-10-95-00002 (Final report, Mar. 1996)
A-04-95-01109 (Final report, Apr. 1996)
A-09-95-00072 (Final report, May 1996)
A-01-95-00006 (Final report, June 1996)
A-06-95-00100 (Final report, July 1996)
A-06-96-00002 (Final report, July 1996)
A-03-96-00200 (Final report, Aug. 1996)
A-03-96-00202 (Final report, Nov. 1996)
A-05-95-00062 (Final report, Dec. 1996)
A-02-95-01009 (Final report, Mar. 1997)
A-03-96-00203 (Final report, Mar. 1997)
A-04-98-01185 (Final report, Sept. 1999)
A-03-00-00204 (Final report, Dec. 2001)

IMPROVE FUNDING SYSTEM FOR MEDICAID ADMINISTRATIVE COSTS

Current Law:

The Federal Government pays for half of the administrative costs for most types of administrative activities in the Medicaid program. States have considerable latitude in defining their administrative costs. Costs need only be considered "reasonable and necessary" as outlined in Office of Management and Budget (OMB) Circular A-87, "Cost Principles for State and Local Governments." In 1996, the Congress enacted the Temporary Assistance for Needy Families (TANF) block grant, which provides grants to States to provide cash to low-income individuals. Since administrative costs are included in this grant, Federal reimbursement for these costs is limited. No such limits apply to the Medicaid program, however.

Proposal:

One of the following options should be used to fund administrative costs in the Medicaid program:

- *Reduction in Medicaid special match rates to 50 percent.*
- *Block grant.* Set a base amount, then provide inflationary increases each year.
- *Standard cost per recipient.* Fund States based on a standard per recipient allocation amount.
- *Cost-per-recipient cap.* Impose a cap on Federal reimbursement of the cost per recipient.

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

The current method for reimbursing States for administrative costs is unwieldy, inefficient, and unpredictable. In addition, there is considerable unexplained disparity in administrative costs among States and significant risk of an increase in administrative costs overall. With the new limits imposed on Federal funding of TANF administrative costs, States have incentives to use accounting techniques to shift administrative costs to the Medicaid program in order to receive Federal reimbursement for these costs.

Savings (in millions):

Options	FY 1	FY 2	FY 3	FY 4	FY 5
Reduced special match	$276	$326	$377	$432	$497
Block grant	137	450	803	1,187	1,617
Standard cost per recipient	38	112	161	233	309
Capped cost per recipient	62	69	79	90	100

Status:

Medicaid administrative costs continue to be paid as they have in the past. The FY 1999 Federal share of administrative costs was $5.3 billion.

Report:

OEI-05-91-01080 (Final report, Jan. 1995

OTHER OPERATING DIVISIONS: *Previous Recommendations*

Other Operating Divisions

Overview

Public Health Agencies. The activities conducted and supported by the public health agencies provide the foundation for the Nation's efforts in promoting and enhancing the continued good health of the American people. These agencies include the National Institutes of Health (NIH), to advance our knowledge through research; the Food and Drug Administration (FDA), to ensure the safety and efficacy of marketed drugs, biological products, and medical devices and the safety of food and cosmetics; the Centers for Disease Control and Prevention (CDC), to combat preventable diseases and protect the public health; the Health Resources and Services Administration (HRSA), to support health care services for low-income and vulnerable populations; the Indian Health Service (IHS), to improve the health status of Native Americans; the Agency for Toxic Substances and Disease Registry (ATSDR), to address issues related to Superfund toxic waste sites; the Agency for Healthcare Research and Quality (AHRQ), to enhance health care services and access to services through scientific research and improvements in clinical practice and in the organization, financing, and delivery of services; and the Substance Abuse and Mental Health Services Administration (SAMHSA), to assist States in refining and expanding treatment and prevention services.

Administration for Children and Families. The Administration for Children and Families (ACF) provides Federal direction and funding for State, local, and private organizations as well as for State-administered programs designed to promote stability, economic security, responsibility, and self-support for the Nation's families. It also oversees a variety of programs that provide social services to the Nation's children, youth, and families; persons with developmental disabilities; and Native Americans.

Significant OIG Activities

The OIG concentrates on such public health issues as biomedical research, substance abuse, acquired immune deficiency syndrome, and food and drug safety. The OIG also reviews the cost effectiveness of ACF social services and assistance programs, including determining whether authorized services are provided to recipients at the lowest costs.

Significant unimplemented monetary recommendations identified by the OIG relate to obtaining favorable rates for inpatient care under the IHS Contract Health Services program and changing OMB Circular A-21 to effect more productive use of Federal research dollars at the Nation's colleges and universities.

REQUIRE HOSPITALS TO ACCEPT MEDICARE RATES IN THE INDIAN HEALTH SERVICE'S CONTRACT HEALTH SERVICES PROGRAM

Current Law:

In administering its Contract Health Services program--a private sector health care purchasing program--IHS relies on voluntary procurement activities with hospitals to obtain favorable rates for inpatient care. Although the law requiring hospitals to accept Medicare rates as payment in full applies to other Federal agencies with similar programs, it does not apply to IHS.

Proposal:

The IHS should revise its legislative proposal to incorporate the updated savings figures presented in our report and should identify elements to be included in the implementing regulations. Also, IHS should continue to pursue the most favorable rates at hospitals that have previously offered less than Medicare rates and should strategically identify and pursue other opportunities where lower rates may be negotiated.

Legislative	Regulatory	Other Administrative
✓	✓	✓

Reason for Action:

As a Federal purchaser of inpatient health care from the private sector, IHS should receive rates commensurate with those received by other Federal agencies that engage in similar purchases. However, IHS paid as much as $8.2 million more than Medicare rates for services provided in FY 1995 because there is no law requiring providers to offer Medicare or lower rates and because the agency has not been fully successful in its efforts to obtain favorable rates through contracts and other procurement mechanisms. If the favorable Medicare rates were legislatively required, the dollars saved could be applied to the backlog of patient services that cannot be accommodated in the Contract Health Services program.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$8.2	*	*	*	*

**Recurring, undetermined savings would result with the legislative change.*

Status:

The IHS fully concurred with our recommendations. However, this item was not included in the Department's FY 2003 budget.

Report:

A-15-97-50001 (Final report, Jan. 1999)

PROPOSE CHANGES TO OFFICE OF MANAGEMENT AND BUDGET CIRCULAR A-21 REGARDING RECHARGE CENTERS

Current Law:

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

Proposal:

The Assistant Secretary for Administration and Management should propose changes to OMB Circular A-21 to improve guidance on the financial management of recharge centers. The revision should include criteria for (1) establishing, monitoring, and adjusting billing rates to eliminate accumulated surpluses and deficits; (2) preventing the use of recharge funds for unrelated purposes and excluding unallowable costs from the calculation of recharge rates; (3) ensuring that Federal projects are billed equitably; and (4) excluding recharge costs from the recalculation of facility and administrative cost rates.

Legislative	Regulatory	Other Administrative
☐	☐	✓

Reason for Action:

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

Savings (in millions):

FYs 1 & 2	FY 3	FY 4	FY 5
$1.9	*	*	*

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

Status:

The Deputy Assistant Secretary for Grants and Acquisition Management concurred with our recommendations, and OMB plans to revise Circular A-21 when additional changes are needed. In addition, the Council on Government Relations generally agreed and stated that the proposed criteria should be included in the Compliance Supplement to OMB Circular A-133, which provides guidance to independent auditors in conducting compliance audits of educational institutions. This suggestion has been forwarded to OMB for consideration.

Report:

A-09-96-04003 (Final report, Mar. 1997)

INTERNET ADDRESS

The *2002 Red Book* and other OIG materials, including final reports issued and OIG program exclusions, may be accessed on the Internet at the following address:

http://www.oig.hhs.gov/