

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**CHANGES ARE NEEDED IN THE WAY
MEDICARE PAYS FOR CLINICAL
LABORATORY TESTS**



JANUARY 1990 · A-09-89-00031

EXECUTIVE SUMMARY

Medicare Pays Nearly Twice as Much as Physicians

Our review of a sample of 1988 billings revealed that Medicare pays, on the average nearly double the prices that large commercial laboratories charge their physician customers for clinical tests. The differences between what Medicare paid and the physician prices were most pronounced for profiles - standardized test packages ordered as a group. While laboratories sold profiles to physicians at substantially discounted prices, Medicare generally paid for them on a test by test basis, at unreduced fee schedule rates.

The laboratories we surveyed generally charged Medicare more than physicians for clinical tests. Indeed, one of the laboratories we reviewed charged Medicare almost five times the prices it charged physicians for the same tests. Laboratory representatives told us that they charged Medicare more because of unnecessary obstacles they faced in obtaining reimbursement from the program.

Medicare Pays Billions for Laboratory Tests

In view of the \$3.9 billion paid by Medicare under Part B for laboratory services in 1987, opportunities exist for significant program savings if Medicare were to pay comparable rates to those charged physicians in a competitive marketplace.

We are recommending that HCFA (i) seek legislation to set the Medicare fee schedules at amounts comparable to what physicians are paying laboratories for the same tests, (ii) develop policies and procedures to ensure that profiles are more appropriately reimbursed, and (iii) work with contractors to simplify the processing of bills from laboratories.

HCFA Favors Paying Competitive Prices for Testing

In written comments to our report, HCFA indicated that it would like to see Medicare paying competitive prices for tests. However, HCFA was not optimistic that Congress would be willing to provide the necessary legislative authority. Even so, HCFA said it would take action to address each of the weaknesses discussed in this report. In addition, HCFA believes that laboratories which engage in price discrimination should be excluded from the Medicare program.

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BACKGROUND

How Laboratories Set Prices

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

High Rates Were Previously Reported

We previously discussed this two-tiered pricing situation, which we termed discriminatory pricing, in an audit report to the HCFA, dated March 8, 1982 ("Despite Years of Attention: Clinical Laboratory Tests Still Cost Medicaid/Medicare Too Much" - ACN 15-20150). In that report, we showed how the Medicare allowances for laboratory tests, which at that time were based on what providers charged the program, exceeded the going market prices that physicians were paying for the same tests. We recommended that Medicare (and Medicaid) take advantage of these competitive market prices and that Medicare not permit laboratories to charge more than they charge physicians for the same tests.

Task Force Reviewed Medicare Policies

In response to our report, HCFA established a task force in 1982 to explore possible reforms of the way in which Medicare paid for clinical laboratory services. The task force's study and report, which was issued February 15, 1984, led to a major legislative change, converting Medicare reimbursement for most laboratory tests to fee schedules.

The HCFA task force recommended setting Medicare fee schedule amounts at less than the then prevailing charges because they believed that the prices billed to Medicare did not reflect a competitive market. The task force assumed that *"the discounted prices of transactions between physicians and independent laboratories reasonably approximate the efficient price of laboratory services in a competitive marketplace."*

**Fee Schedules
Were
Established**

The Medicare fee schedules went into effect July 1, 1984, for clinical tests reimbursed under Part B of the Medicare program. The fee schedule rates applied to tests performed on outpatients, whether done in physician offices, independent clinical laboratories, or hospital laboratories. Tests done on hospital inpatients were not subject to fee schedules, but rather paid through either fixed hospital rates or on the basis of reasonable costs by Medicare.

Under the fee schedules, Medicare allowances for laboratory services varied by geographical location. Different allowances were set by each of the contractors (carriers) which processed and paid Medicare Part B claims billed by physicians or independent laboratories. Hospital laboratories, for outpatient services, generally submitted Part B claims to other contractors, called intermediaries, which paid according to these carrier set fees. In general, the fees were established at 60 percent of the Medicare prevailing rate during a base period at each carrier, and were periodically updated to reflect inflation. (Hospital laboratories were initially paid at 62 percent of the prevailing rate.)

Medicare payments for laboratory tests under the fee schedules had to be on the basis of assigned claims. In addition, the usual Medicare Part B deductible and coinsurance were waived. Providers billing the program had to accept the fee schedule allowance as payment in full, and beneficiaries were not liable for any cost sharing on claims for which Medicare made payment. In general, the provider who performed a test had to bill the program. That is, physicians were no longer permitted to purchase tests from independent laboratories and then bill Medicare.

**Concerns Were
Again Raised
Over Rates**

At the time the Medicare fee schedules were originally being developed, we expressed concern to HCFA over setting the rates at 60 percent of the Medicare prevailing. Based on our limited review of prices available to physicians, we concluded that these rates might be high.

Congress, also concerned about the appropriate levels of Medicare reimbursement for laboratory tests, requested the General Accounting Office (GAO) to do two studies of the Medicare fee schedules. In the first of these two studies (HRD-88-32, December 1987), the GAO reported that the fee schedules, as initially set, did not produce any significant program savings, although beneficiaries saved an estimated \$313 million due to waived cost sharing on claims for laboratory services. The second study, which will involve an analysis of providers' costs and revenues, is due by January 1, 1990.

Changes Have Been Made in Fees

Congress first modified the fee schedule allowances, effective July 1, 1986, by imposing national ceilings, or payment caps, on what individual carriers could pay. These ceilings were initially set at 115 percent of the median of all carrier rates. Carriers paid the lowest of the national fee schedule amount, each carrier's fee schedule amount, or the laboratory's charge.

In its fiscal year 1988 legislative program, HCFA proposed a reduction in Medicare payment rates for laboratory services, citing previous studies by the Inspector General and the GAO. In response to this proposal, Congress mandated specific reductions in the rates, effective April 1, 1988. Certain tests, including automated chemistries and other commonly performed tests, were reduced by 8.3 percent. In addition, the national ceilings were limited to the median of all fee schedule allowances, instead of 115 percent of the median as was previously used.

In contrast to the above reductions, the payment rates have been increased three times since 1984, to reflect changes in the consumer price index. Overall, these "automatic" payment rate updates (they may be modified only by Congressional action) have increased the fee schedule allowances by 14.1 percent, representing the compounding effect of periodic inflation adjustments totaling 13.5 percent.

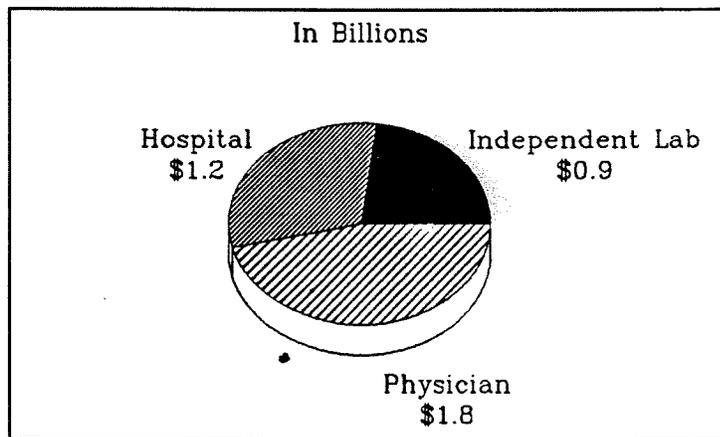
Medicare Paid Billions For Tests

According to data maintained by HCFA, Medicare Part B payments were about \$3.9 billion for laboratory services in fiscal year 1987, the most recent year for which it had statistics. This represented a 22 percent increase from the \$3.2 billion HCFA data showed was spent in fiscal year 1986. Figure 1 shows a breakdown of the 1987 payment data by type of provider.

Figure 1

Laboratory payments by type of provider.

Medicare Part B - Laboratory Services
1987 Payments



SCOPE OF AUDIT

The objective of our review was to compare Medicare payment rates for clinical laboratory tests to the prices which large commercial laboratories charged physicians.

In conducting our audit, we obtained Medicare payment rate data and reviewed selected claim processing procedures used by 41 carriers in 38 States. In addition, we visited high volume laboratories in California, Florida, New Jersey and Texas. Medicare payments in these States accounted for about one-third of the amounts all carriers paid for laboratory services in fiscal year 1987. We surveyed pricing practices at 26 laboratories in these States and judgmentally selected seven of them for more detailed review.

Using multistage sampling, we randomly selected monthly invoices sent to physicians and line items on the invoices at each laboratory. We then compared the prices the physicians or other providers paid to the Medicare rates for the same tests. The bills we reviewed at each laboratory were for a one-month period subsequent to April 1, 1988, the date of the most recent Medicare rate reduction.

In 1987, Smith Barney Research published an investment report entitled "The Clinical Laboratory Industry." This report indicated that six national chains comprised about one-third of the independent laboratory segment of the total industry. Our detailed review included five of the six industry giants. In total, the seven laboratories we reviewed in detail were owned by corporations having 116 separate license numbers for billing Medicare carriers across the nation. The seven laboratories were National Health Laboratories, Inc., and Medical Laboratory Network in California; Damon Clinical Laboratories and Smith-Kline/Bio-Sciences Laboratories in Florida; Metpath Laboratories in New Jersey; and National Health Laboratories, Inc., and International Clinical Laboratories, Inc., in Texas.

Our field work was performed between February 1988 and January 1989. The review was conducted in accordance with generally accepted government auditing standards.

RESULTS OF REVIEW

Medicare Was Paying More Than Physicians

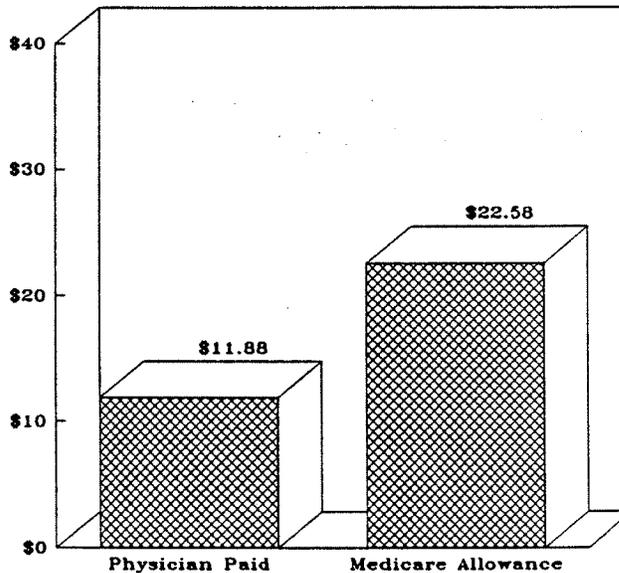
Most of the laboratories we visited had established separate price lists which applied to physicians, not Medicare. However, we discovered that a comparison of these prices to the Medicare payment rates would not be realistic due to the fact that physicians usually obtained discounts from the price lists. Therefore, we selected seven laboratories doing substantial billing to physicians for further study.

Our detailed review of 4,120 billings to 211 physicians revealed that the Medicare payment rates were about 90 percent more than the amounts which were actually paid by the physicians. Put another way, the Medicare rates would have to be nearly cut in half to make them equivalent to the prices physicians were paying for the same tests. The difference in prices is shown in Figure 2.

Figure 2

Average amount paid by the physicians compared to average amount Medicare would have allowed.

Physician vs Medicare
Average Payments



The Medicare national ceilings for our sample items exceeded the physician prices by a slightly greater amount, as they were 99 percent more than what the physicians paid. The results for each laboratory are shown in Exhibits A-1 through A-3.

The Medicare rates did not exceed the physician prices in the case of all tests. Rather, Medicare paid more for certain common, high volume services such as profiles and automated chemistries, while it paid less for certain less frequently ordered tests, such as HIV antibody detection. This suggests that Medicare needs to make both upward and downward adjustments to its fee schedule allowances. The prices we observed for selected tests are shown in Exhibits B-1 through B-3.

The legislation which created the fee schedule method of paying for laboratory tests permitted Medicare to make rate adjustments for high cost, low volume tests. No such authority, however, was granted for tests which appear to be the most excessively reimbursed by Medicare, i.e., low cost, high volume tests. Thus, new legislation would be required to make appropriate adjustments to the fee schedule allowances.

Profiles Were Paid For At Unreduced Rates

Some of the most dramatic differences in prices in our sample occurred when physicians ordered profiles. These services consisted of certain combinations of tests which, when ordered as a group, were offered to physicians as a package at reduced rates.

To illustrate, one profile which was commonly ordered consisted of an automated chemistry test, a complete blood count, and two thyroid tests. One of the laboratories sold this profile to a physician for \$9.50. Yet, Medicare would have been billed for each of the individual tests in the profile separately, at a total price of \$66.50. Even though the fee schedule allowances were limited to \$45.19, this was still nearly five times what the physician paid. Figure 3 shows how Medicare would have paid the tests individually, while additional examples are shown in Exhibit B-3.

Figure 3

Example of Profile

Comparison of what the physician paid for the profile to what Medicare would have allowed.

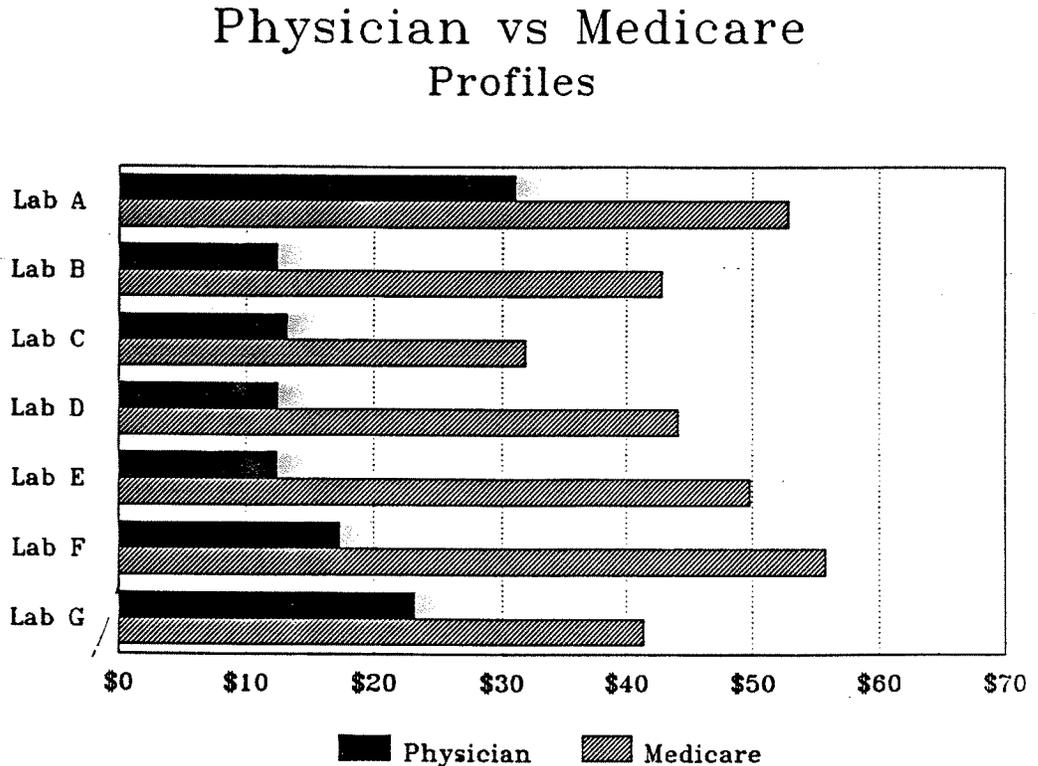
<u>List of Tests</u>	<u>Physician Paid</u>	<u>Medicare Allowed</u>
Automated Chemistry		\$16.92
Complete Blood Count		7.83
Thyroxine		10.53
Triiodothyronine (T-3)		9.91
Total	\$9.50	\$45.19

Profiles were frequently ordered. In our sample of 4,120, there were 1,525 profiles requested by physicians. In other words, 37 percent of the billings to physicians was for profiles, or standardized packages of tests ordered by physicians.

Even though profiles were common, Medicare did not insure that reasonable prices were paid. For the most part, Medicare paid for profiles as individual tests at the full fee schedule allowances. Also, no national ceilings were set for any of the billing codes established for profiles. Medicare, unlike physicians, generally did not benefit when standard test packages were ordered from the laboratories.

For the 1,525 profiles in our sample, Medicare was paying 176 percent more than the prices paid by physicians for the same tests. The national ceilings for the individually billed procedures were slightly higher, as they were 186 percent more than the physicians paid. Figure 4 shows how much more Medicare was paying for profiles at each laboratory.

Figure 4
Comparison of physician payment to Medicare allowance for profiles.



Some carriers have recognized the need to limit Medicare payment for profile tests. However, their efforts to establish more reasonable rates under Medicare have been hampered by the rigid way in which the fee schedule rates have been developed. For example, HCFA has advised carriers that, based on legislative intent, they are not permitted to exercise the "inherent reasonableness" authority that they use to set rates for certain other Medicare services. Also, they may not apply "comparability" limitations which are payment restrictions applicable to non-Medicare insurance plans.

Even in cases where carriers did use profile codes (80050 through 80099) for Medicare payment purposes, there was considerable variation in approach. Some carriers simply paid the codes as billed by providers without any attempt to determine what tests were included, while other carriers had gone to considerable effort to designate the tests included in a profile. Of the 41 carriers we surveyed, 18 had some guidelines for tests normally found in particular profiles. For example, a thyroid profile typically included free thyroxine index (T-7), thyroxine (TT-4), and triiodothyronine (T-3). Even when the carriers generally agreed on the content of the profile, the amount they would allow varied greatly - from \$10.31 to \$45.56. Even greater variances were common for other profiles. For example, the carrier allowances for a pituitary profile ranged from \$16.44 to \$252.35.

Although carriers have sought guidance on how to reimburse profiles, HCFA has been reluctant to develop a national approach. Instead, it has been left to carriers to adopt procedures which are consistent with local billing patterns. Our review, however, indicated that the problem of excessive payments for profiles was national in scope, and that the large chain laboratories established standardized test packages that were similar throughout the country. While local variations would appear to be appropriate, HCFA needs to develop overall policies and procedures to insure that effective payment limitations are put in place by all carriers.

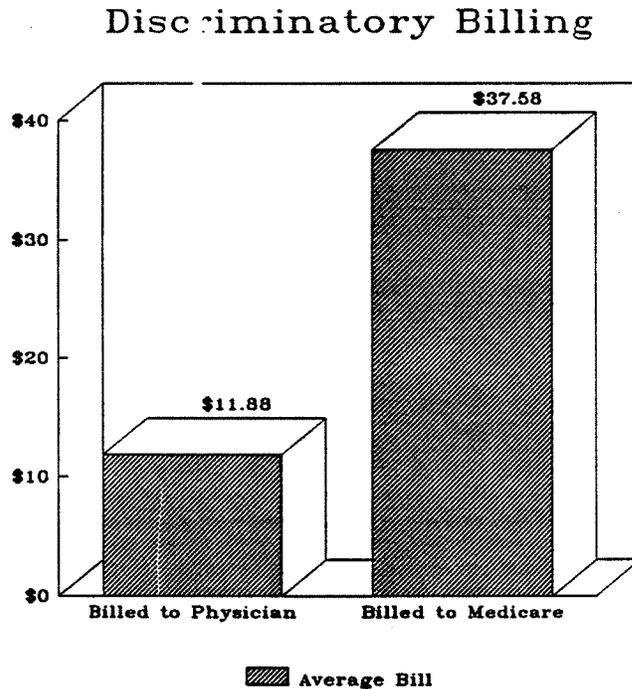
**Discriminatory
Pricing Was
Prevalent**

Of the 26 independent clinical laboratories we surveyed, 19 had established separate price lists for their physician and other health provider customers. The remaining seven laboratories generally specialized in providing services to nursing homes or dialysis clinics and did not extensively bill physicians for laboratory testing. While the price lists for physicians showed lower rates than those billed to Medicare and other third-party payers, we found that most physicians were given additional discounts from the list prices.

Our detailed review of actual billings provided a more realistic basis for comparing what the laboratories were charging physicians to the amounts they billed Medicare for the same tests. The seven laboratories we reviewed in detail charged Medicare over three times what they asked physicians to pay for the same tests. The average difference in price is shown in Figure 5.

Figure 5

Average amount billed to physicians compared to amount laboratory would have billed to Medicare.



One laboratory charged Medicare nearly five times what it charged physicians, while all seven billed the program at least twice as much for services as they received from their health provider customers, as shown in Exhibit A-1.

It should be noted that the Medicare program has condoned pricing differentials on the part of independent laboratories. Under the method Medicare used to pay for clinical tests prior to the fee schedules, HCFA instructed carriers to disregard laboratories' charges to physicians in establishing the providers' "customary" charges, used to limit Medicare allowances. Also, HCFA decided not to seek legislation to prohibit price discrimination, even though we recommended HCFA do so in our 1982 report.

When we asked laboratory representatives why they charged Medicare more than physicians, the most common response was that it cost more to bill and obtain reimbursement from Medicare. As an example, representatives at one laboratory showed us a stack of checks they said they had just received from Medicare. The laboratory, they explained,

had billed for some 500 Medicare patients, using a single computer tape. Instead of issuing just one check for the entire billing, as its physician customers did, the laboratory's carrier had paid with a separate check for each patient. The carrier's use of separate checks for each patient obviously was inefficient and unnecessary from the perspective of both the laboratory and the Medicare program.

Another common complaint we heard was that Medicare carriers sometimes demanded information that was difficult for the laboratory to obtain, such as the patient's diagnosis. Assuming that the patient's diagnosis was needed to check on the medical necessity of the tests, it would be more logical for the ordering physician to provide the information, rather than the referral laboratory.

Medicare Was a Large Volume Payer of Tests

Although the laboratories provided evidence that Medicare needed to simplify the way in which it processed and paid claims, they overlooked the fact that Medicare was a large volume payer of tests. The Smith Barney Research report on the clinical laboratory industry estimated that Medicare represented 10 to 20 percent of the total testing performed. At one of the laboratories we visited, Medicare made up about 30 percent of the corporate revenues nationwide. Because Medicare is such a large volume payer of tests, we believe a strong case could be made for Medicare paying less than physicians. Certainly, the program should not be asked to pay more.

The laboratories' complaints also ignored the fact that the normal coinsurance and deductible requirements, which otherwise applied to Medicare and other insurance plans, were waived under the fee schedules. Patient cost sharing is a standard technique employed by health insurance plans to help control the utilization of services. The cost sharing requirements that usually apply to Medicare were waived under the fee schedule to simplify billings to the program. In return, Medicare expected to pay comparable prices to those charged physicians.

The waiver of coinsurance on Medicare laboratory claims under the fee schedules was a major concession to the industry. According to Congressional Budget Office estimates, the waiver will cost Medicare about \$2.9 billion over the next 5 years. Thus, the program has every reason to expect to be charged competitive prices for laboratory tests. If Medicare does not obtain the benefit of going market prices, then the waiver of cost sharing should, in our opinion, be reconsidered.

CONCLUSIONS AND RECOMMENDATIONS

The Medicare payment rates for clinical tests were considerably higher than the prices large commercial laboratories were charging physicians for the same tests. This was particularly true for profiles, or test packages, which were sold to physicians at reduced prices.

In addition, independent laboratories charged Medicare much more than physicians for the same tests. Laboratory representatives told us they charged Medicare more because of unnecessary billing complications, even though they no longer had to bill beneficiaries for cost sharing.

With Part B payments of \$3.9 billion for laboratory services in 1987, Medicare could achieve significant savings by paying fees comparable to those charged to physicians in a competitive marketplace.

We recommend that HCFA:

1. Seek legislation to allow across-the-board adjustments in Medicare laboratory fee schedules, bringing them in line with the prices which laboratories charge physicians in a competitive marketplace.
2. Develop policies and procedures, including any needed legislative changes, to insure that the program benefits from reduced prices when profiles are ordered on behalf of Medicare patients. At a minimum this would entail (i) a requirement that laboratories identify and bill profiles at reduced rates whenever they are ordered and (ii) a method of paying for profiles at substantially less than the full price for the individual tests.
3. Work with carriers to further streamline the processing of Medicare claims for laboratory services.

SUMMARY OF HCFA COMMENTS

In written comments to our report, HCFA pointed out that Congress has repeatedly legislated against its attempts to achieve market prices through competitive bidding. Thus, HCFA does not believe Congress would provide the necessary legislative authority to allow Medicare to establish competitive payment rates.

In addition, HCFA pointed out certain practical difficulties it would have in implementing our recommendations. Nevertheless, HCFA plans the following corrective actions:

1. It will attempt to reduce the gap between Medicare and physician prices through legislative budget proposals.
2. It will work toward the establishment of national ceilings for standard profiles.
3. It will investigate the billing complications highlighted in our report to insure the efficient processing of claims.

Finally, HCFA said that laboratories which engage in price discrimination should be excluded from the Medicare program.

A complete text of HCFA's written comments is included as an Appendix to this report.

E X H I B I T S

EXHIBIT A-1

Results by Laboratory As a Percent of Physician Bill

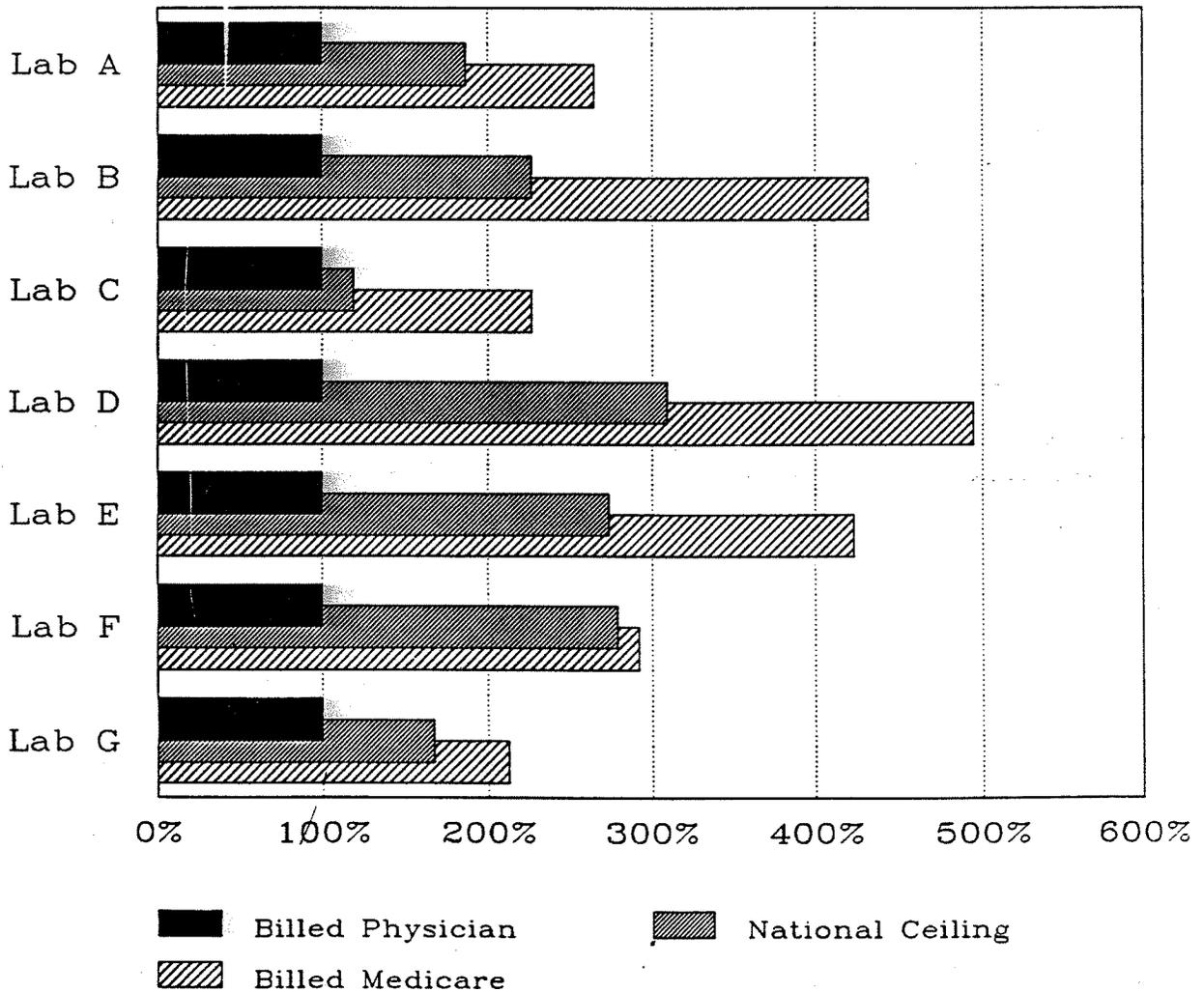


EXHIBIT A-2

Results by Laboratory Average Dollar Values

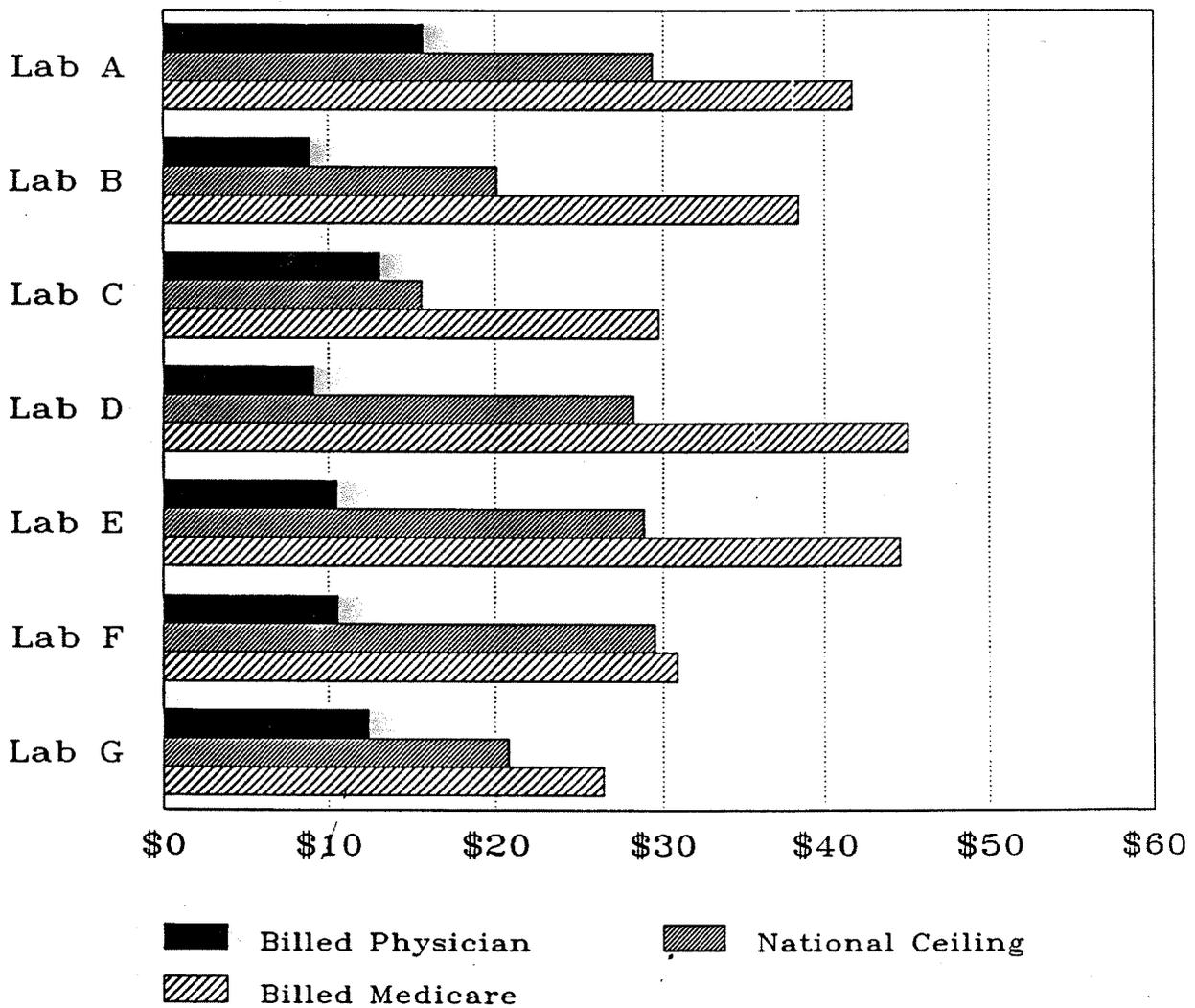


EXHIBIT A-3

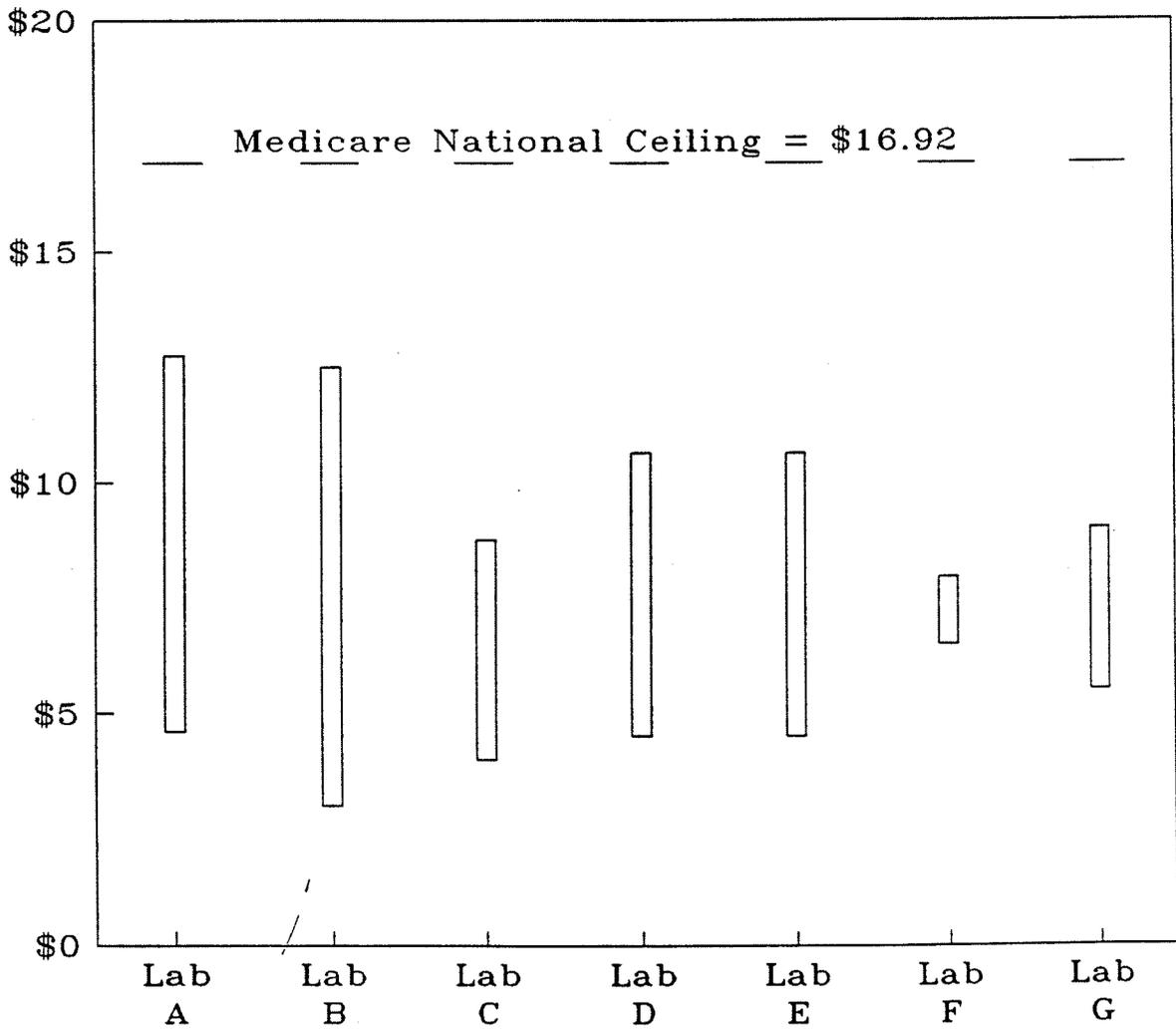
Average Amount per Item Billed at Seven Laboratories

	<u>Number of Items</u>	<u>Billed to Physicians</u>	<u>Billed to Medicare</u>	<u>Carrier Allowed</u>	<u>National Ceiling</u>
Lab A	561	\$15.75	\$41.72	\$25.79	\$29.37
Lab B	819	\$8.89	\$38.38	\$19.85	\$20.13
Lab C	463	\$13.14	\$29.75	\$14.82	\$15.66
Lab D	706	\$9.12	\$45.13	\$27.46	\$28.23
Lab E	623	\$10.51	\$44.63	\$28.50	\$28.88
Lab F	519	\$10.59	\$30.92	\$29.41	\$29.54
Lab G	429	\$12.44	\$26.43	\$20.67	\$20.81
Total	4,120				
Average		\$11.88	\$37.58	\$22.58	\$23.64

The Average amounts are weighted by each laboratory's billing volume.

EXHIBIT B-1

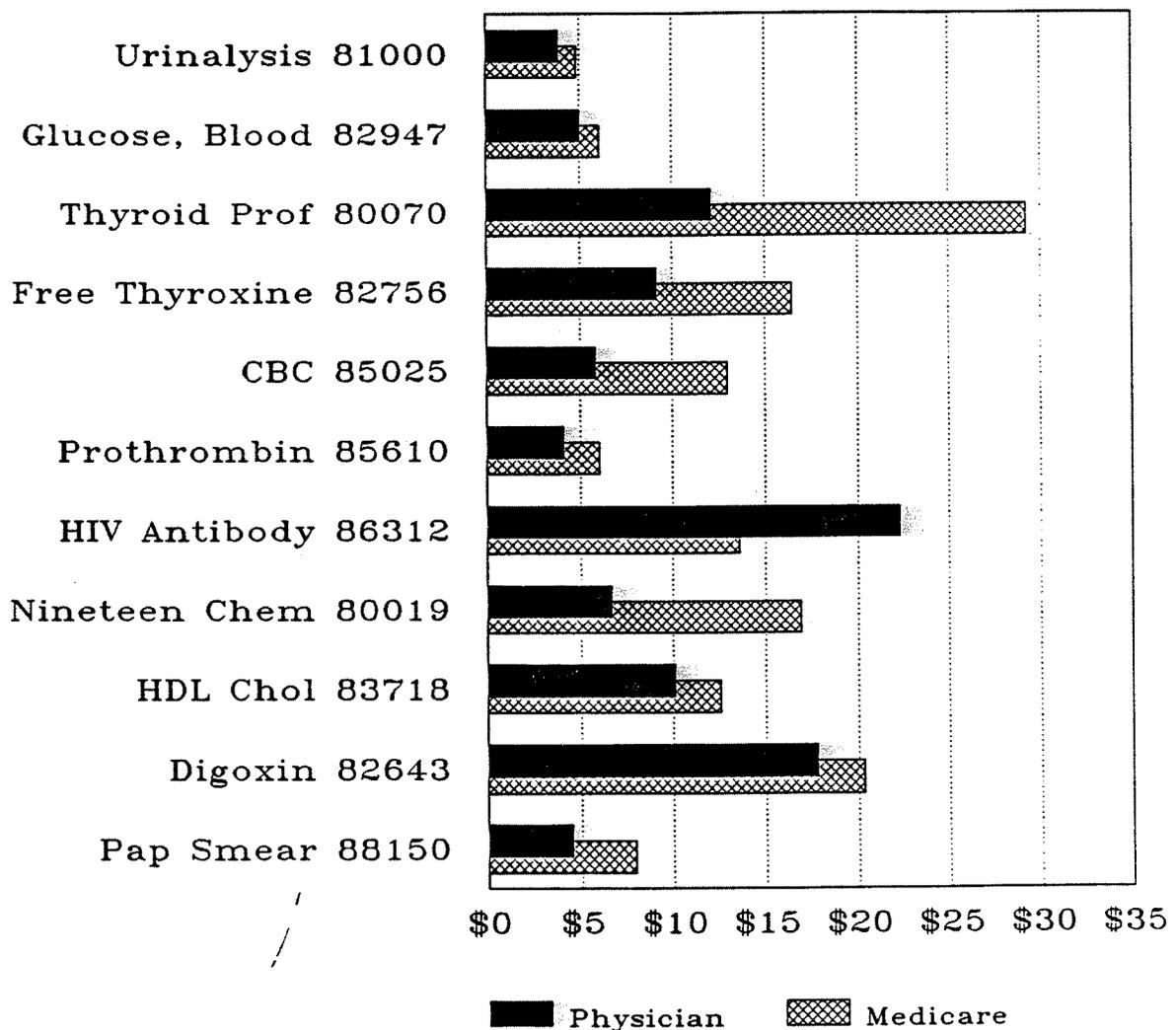
Automated Chemistry Test Procedure Code 80019



Range of Amounts Paid by Physicians
Compared to the Medicare Ceiling

EXHIBIT B-2

Prices for Selected Tests



Average Amounts Billed Physicians
Compared to Medicare National Ceiling

EXHIBIT E-3

Typical Examples of Profiles

<u>List of Tests</u>	<u>Physician Paid</u>	<u>Billed Medicare</u>	<u>Medicare Allowed</u>
Automated Chemistry Test		\$27.60	\$16.92
Lipoprotein Cholesterol		26.80	19.71
Total	\$11.00	\$54.40	\$36.63
<hr/>			
Automated Chemistry Test		\$27.60	\$16.92
HDL Cholesterol		26.80	19.71
Thyroxine		22.35	10.54
Complete Blood Count		16.80	12.96
Total	\$17.00	\$93.55	\$60.13
<hr/>			
Triiodothyronine		\$11.52	\$ 9.91
Thyroxine		12.98	10.53
Total	\$ 5.75	\$24.50	\$20.44
<hr/>			
Automated Chemistry Test		\$21.20	\$16.92
Thyroxine		12.10	10.53
Complete Blood Count		11.40	9.91
Total	\$22.25	\$44.70	\$37.36
<hr/>			
Automated Chemistry Test		\$14.10	\$13.92
HDL Cholesterol		12.71	12.55
CBC with Differential		13.16	12.99
Macro Urine		3.31	3.27
Urogram		3.33	3.29
Micro Urine		4.74	4.64
Total	\$12.50	\$51.35	\$50.66

A P P E N D I X

COMMENTS FROM THE ACTING ADMINISTRATOR OF HEALTH CARE FINANCING ADMINISTRATION



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Memorandum

Date NOV 15 1989

From Louis B. Hays *Louis B. Hays*
Acting Administrator

Subject OIG Final Audit Report: Changes are Needed in the Way Medicare Pays
for Clinical Laboratory Tests — (A-09-89-00031)

To The Inspector General
Office of the Secretary

We have reviewed the above subject final audit report. We apologize that our response to the draft report was late, which precluded the use of our comments in your final report. Please consider my memorandum of September 22, 1989 (attached), as the response to this final report with the following additional comments.

- o We will advise each carrier to: (1) determine the tests included in each profile; (2) ensure that the amount paid for the profile does not exceed the sum of the fee schedule amounts or national limitations if lower, for the individual tests; and (3) report the test content and payment allowance by the common profiles to us for possible establishment of national limitations on those profiles with standard definitions.
- o We believe OIG should initiate a legislative proposal to enhance its authority to administer section 1128(b)(6) of the Social Security Act which relates to discriminatory pricing. This might include, for example, explicit authority to gather data from laboratories on their charges to non-Medicare patients and any other clarifications needed by OIG to better administer this provision.
- o We will consider initiating a legislative proposal giving HCFA the ability to reduce the national limitation amounts for specific laboratory test if we can obtain reliable data indicating that the fee schedule amounts for these tests are grossly excessive. A possible source of these data is information gathered by OIG on amounts charged by national laboratories to their non-Medicare patients. We are not optimistic however, about Congress' willingness to give us this authority, given the prescriptive manner in which the fee schedule legislation has been written and the legislative history against competitive bidding.

We respectfully request that you issue a revised final report incorporating our comments. Please advise us whether you agree with our position at your earliest convenience.

Attachment

COMMENTS FROM THE ACTING ADMINISTRATOR OF HEALTH CARE FINANCING ADMINISTRATION



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

SEP 22 1989

Memorandum

Date

From

Louis B. Hays
Acting Administrator

Subject

OIG Draft Report: Changes Are Needed In The Way Medicare Pays for Clinical
Laboratory Tests - CIN: A-09-89-00031

To

The Inspector General
Office of the Secretary

We are responding to your request for comments on a draft report concerning clinical laboratory fee schedules. In the report, you find that Medicare allowances are higher than prices laboratories charge physicians, and you find that laboratories charge Medicare more than they charge physicians. You recommend that HHA bring Medicare payment rates for clinical tests in line with the prices laboratories charge physicians in a competitive marketplace. To accomplish this end, you recommend HHA: (1) seek legislation; (2) develop policies and procedures to ensure Medicare requires laboratories to identify and bill profiles at reduced rates and pay for profiles at substantially less than the full price for individual tests; and (3) work with carriers to further streamline the processing of Medicare claims for laboratory services.

Regarding your recommendation that HHA seek legislation to bring Medicare payment rates for clinical tests in line with the prices laboratories charge physicians in a competitive marketplace, we do not believe this recommendation has been developed sufficiently for HHA to take action. There is no indication of how HHA would determine the prices laboratories charge physicians. At the least, OIG should have presented an approach to determine such pricing. In addition, and as you are well aware, Congress has repeatedly legislated against HHA attempts to experiment with competitive bidding to achieve marketplace prices. Although linking payment rates directly to commercial prices for physicians is problematic, the Administration's FY 1991 budget proposal does contain a provision to reduce the national limitation amount by 10 percent. This will narrow the gap you have identified, keeping in mind that there probably is a dynamic at work which would cause laboratories to increase physician charges when Medicare lowers its payment. This sort of incremental reduction is probably the best course of action when the interplay of cost and profits in two market sectors is not clear and fully understood.

COMMENTS FROM THE ACTING ADMINISTRATOR OF HEALTH CARE FINANCING ADMINISTRATION

Page 2 - The Inspector General

With respect to your recommendation that HFA develop policies and procedures to ensure that Medicare identify and bill profiles at reduced rates, we do not believe that the recommendation can be accomplished without legislation. With respect to the minimum requirements you delineate in this recommendation, we believe a system capable of documenting the physician's order to the laboratory and linking the order to the laboratory's bill would be unwieldy at best. We believe any requirement for laboratories to bill at a lower rate should be linked to section 1128 of the Social Security Act (see discussion below). Finally it is unclear what method you have in mind to pay substantially less than the full price for the individual tests. We have further doubts about the efficiency of your recommendation that HFA routinely pay reduced prices for profiles because we suspect that laboratories will respond by advising physicians to order tests in a disaggregated manner. For these reasons, we do not concur with this recommendation.

With respect to your recommendation that HFA work with carriers to streamline the processing of Medicare claims for laboratory services, we will consider any suggestions OIG offers regarding ways by which this may be accomplished. Moreover, several carrier practices enumerated in the OIG report will be investigated and corrective action taken if carriers are not in compliance with current operating guidelines.

The recommendations of this audit report are directed to lowering Medicare payment rates and forcing laboratories to bill at lowered prices. The process recommended is to seek new legislative authority and create implementation procedures which have not yet been conceptualized. While there is only negative legislative history for efforts to achieve marketplace prices from a payment perspective (i.e., the rejection of competitive bidding), there is clear legislative support for action on price discrimination against Medicare. Section 1128(b)(6) calls for exclusion of those who charge Medicare substantially in excess of the usual charges. It seems that Congress has already foreseen the problem of discriminatory pricing and legislated the remedy. Congress did not call for adjusting payment allowances; rather, it called for the much more severe consequence of program exclusion. The aggressive application of section 1128 would resolve most of the problems identified in this report. We believe laboratories will not risk losing all Medicare business in order to continue such discrimination and the market would soon adjust to a uniform pricing policy. However, it is essential that HFA receive guidance from your office on case development referral for section 1128(b)(6) action.

Thank you for the opportunity to comment on this report.