

OFFICE OF INSPECTOR GENERAL  
**RED BOOK**



2005

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## *Office of Inspector General*

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

### *Office of Audit Services*

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

### *Office of Evaluation and Inspections*

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide the Department, Congress, and the public with timely, useful, and reliable information on significant issues. Specifically, these evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness in departmental programs. To promote impact, the reports also present practical recommendations for improving program operations.

### *Office of Investigations*

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

### *Office of Counsel to the Inspector General*

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

# Introduction

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## **Purpose of the Red Book**

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

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

The savings estimates indicated for these unimplemented recommendations are updated to reflect more current information as it becomes available. The estimates have varying levels of precision. Full implementation of the recommendations in the 2006 edition of the *Red Book* could produce substantial savings to the Department of Health and Human Services (HHS). We hope this edition will prove useful to departmental decisionmakers, the Administration, and Congress in their continuing efforts to contain costs and improve program efficiency at HHS.

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## **Department of Health and Human Services**

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

- The Centers for Medicare & Medicaid Services (CMS) administers the Medicare and Medicaid programs, as well as the State Children's Health Insurance Program (SCHIP) and the new Medicare Part D and Medicare Advantage programs. These programs, which account for over 80 percent of the HHS budget, provide medical care coverage for senior citizens, people who have disabilities or who are economically disadvantaged, and children whose families earn too much to qualify for Medicaid but too little to afford private coverage.
- The public health agencies include the National Institutes of Health, the Food and Drug Administration, the Centers for Disease Control and Prevention, the Health Resources and Services Administration, the Indian Health Service, the Agency for Healthcare Research and Quality, and the Substance Abuse and Mental Health Services Administration. They promote biomedical research and disease cure and prevention; ensure the safety and efficacy of marketed food, drugs, and medical devices; and conduct other activities designed to ensure the general health and safety of American citizens.

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

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## Significant OIG Activities

Over the years, our findings and recommendations have contributed to many significant reforms and substantial savings in departmental programs. For fiscal year (FY) 2005, we reported savings and expected recoveries of nearly \$35.4 billion. Such changes included capping the Medicaid upper payment limit, establishing a Medicare prospective payment system and consolidated billing for skilled nursing facilities, and restructuring Medicare home health payments.

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## Organization of the Red Book

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

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

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

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## New Recommendations

# Medicare Reimbursement

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## Stop Inappropriate Payments for Chiropractic 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 required that subluxations be demonstrated by an x-ray or physical examination. In addition to these specific provisions, sections 1862(a)(1)(A) and 1988(e) of the Social Security Act require that all services billed to Medicare, including chiropractic manipulations, be medically necessary and supported by documentation.

**Proposal (✓*Procedural*):** CMS should ensure that chiropractic services comply with Medicare coverage criteria and require that its carriers educate chiropractors on Medicare Carriers Manual requirements for supporting documentation.

**Reason for Action:** Sixty-seven percent of chiropractic services provided to Medicare beneficiaries in 2001 did not meet Medicare coverage criteria and documentation requirements, potentially costing the program and its beneficiaries approximately \$285 million. Specifically, we found that the majority of inappropriately paid services were maintenance treatments (\$186 million unallowed payments).

**Savings (in Millions):**

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
\$285	TBD	TBD	TBD	TBD

**Status:** CMS agreed with our findings and recommendations. CMS has clarified its chiropractic coverage criteria and indicated that most carriers are taking steps to reduce chiropractic error rates, including targeted educational efforts and service specific medical reviews. In addition, as of October 1, 2004, CMS has required that chiropractors use the AT modifier to indicate that a service is not maintenance; only claims to which the modifier is attached are payable.

**Reports:**

- OEI-06-97-00480 (final report, 9/98)
- OEI-04-97-00490 (final report, 11/98)
- OEI-09-02-00530 (final report, 5/05)

# Medicaid Reimbursement

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## CMS Oversight of Cost-Avoidance Waivers

**Current Law:** Medicaid is required to be the payer of last resort when a beneficiary has coverage under a third-party source such as Medicare, State worker’s compensation, or private health insurance. Millions of Medicaid beneficiaries have additional health insurance through such third-party payers. Pursuant to 42 CFR § 433.145, when Medicaid beneficiaries have a right to payment for medical care from insurance or another third party source, Medicaid has a legal right to payment from these sources. Consequently, Medicaid agencies should avoid costs by denying claims from providers who can then bill a liable party. However, Federal regulations (42 CFR § 433.138) allow CMS to grant cost-avoidance waivers enabling State Medicaid agencies to “pay-and-chase” by paying providers upfront 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 (✓Regulatory, ✓Procedural, ✓Legislative):** CMS should improve its oversight waivers of the cost-avoidance waiver process and require States to track the amount of money they attempt to recover from third parties.

**Reason for Action:** In 14 States with cost-avoidance waivers we identified \$307 million in outstanding payments potentially owed by liable third parties in Federal fiscal year 2000. This amount is considered to be an outstanding debt because the Medicaid program has paid out money, yet the dollars associated with these claims have not been not recovered by the State nor validly denied by the third party.

**Savings (in Millions):**

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
\$307	\$307	\$307	\$307	\$307

**Status:** CMS agreed that the agency should improve its oversight of the cost-avoidance waiver process. CMS also expressed belief that the implementation of the Health Insurance Portability and Accountability Act (HIPAA) electronic billing standards has enabled providers to bill liable third parties more easily, thereby reducing Medicaid third party recovery activities. CMS is continuing to promote States’ increased and appropriate use of cost avoidance, and will, in the future, reassess the impact of HIPAA electronic billing on third party recoveries. The President’s FY 2007 Budget proposes to discontinue all waivers that permit pay and chase of pharmacy claims.

**Report:**

OEI-03-00-00031 (final report, 2/04)

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## Applying the National Correct Coding Initiative to Medicaid Services

**Current Law:** CMS implemented the National Correct Coding Initiative (NCCI) in January 1996 to promote correct coding of health care services by providers and to prevent Medicare payment for improperly coded services. Although use of NCCI edits is mandatory in the Medicare program, State Medicaid agencies are not currently required to use these edits in processing their claims.

**Proposal (✓Procedural):** CMS should encourage States to explore the use of Medicare CCI edits within their Medicaid programs.

**Reason for Action:** We found that most State agencies do not use the Medicare NCCI edits. Only seven States use all or some of these coding edits. Thirty-nine Medicaid agencies paid \$54 million in 2001 for services that would have been denied based on NCCI edits. Using these edits would promote correct coding by providers and reduce Medicaid expenditures for services that the edits would deny.

**Savings (in Millions):**

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
\$54	\$54	\$54	\$54	\$54

**Status:** CMS concurred with our recommendation. As of January 2006, CMS has discussed NCCI with both the CMS Regional Office Medicaid analysts and the State Systems Technical Advisory Group and has asked the States to review the Medicare NCCI edits against their own policies and adopt those edits that apply, unless State edits are in conflict or exceed those developed by CMS for Medicare. In addition, CMS will provide the States with the Medicare NCCI Web site and 2004 OIG report. CMS's Regional Offices will follow up with the States during their on-going discussions throughout 2006. Finally, CMS will highlight the value of the NCCI at the next annual Medicaid Management Information System conference.

**Report:**

OEI-03-02-00790 (final report, 10/04)

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## Ability of Noncustodial Parents To Contribute Towards Their Children's SCHIP Costs

**Current Law:** Current regulations require the State Title IV-D agency to petition the court or administrative authority, unless the custodial parent and children have satisfactory health insurance other than Medicaid, to include health insurance that is available to the noncustodial parent at reasonable cost in new or modified orders for support. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 directs the Title IV-D agency to notify an employer of a noncustodial parent's medical support obligation and directly enroll his or her children if a health plan is available. Title XXI of the Social Security Act, which authorizes the State Children's Health Insurance Program (SCHIP), is silent with regard to collecting SCHIP costs from noncustodial parents who have a medical support order.

**Proposal (✓Procedural):** CMS should (1) issue program guidance to advise States of their authorities under Federal law to collect SCHIP costs from noncustodial parents; and (2) determine whether additional Federal funds are needed to assist States in interfacing their Title IV-D and SCHIP databases and implementing a process to collect SCHIP costs from noncustodial parents and, as appropriate, provide such funds.

**Reason for Action:** States have an opportunity to enroll uninsured Title IV-D children in SCHIP and provide a means for noncustodial parents to fulfill their medical support obligations. Unlike Federal Medicaid laws, SCHIP laws are silent with regard to an "assignment of rights" that would allow States to recover children's medical expenses from their noncustodial parents. While some States have already taken steps to collect SCHIP costs from noncustodial parents, others have questioned their authority to do so. Also, some States expressed concern about the costs of interfacing their Title IV-D and SCHIP databases and implementing administrative and policy changes to recover SCHIP costs from noncustodial parents. According to these States, they may not achieve the full savings that we identified without additional Federal funds and/or incentive payments.

**Savings (in Millions):**

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
\$14*	TBD*	TBD*	TBD*	TBD*

*\*The FY1 estimate is based on our review of eight States. We did not quantify savings for future years.*

**Status:** CMS alerted States of their option to pursue the Federal and State shares of SCHIP costs. CMS provided this information to States through the CMS SCHIP Technical Advisory Group and through its Regional Offices. As an additional effort to ensure that States are knowledgeable about their authorities under Federal law to collect SCHIP cost from non-custodial parents, CMS participated in the Medical Support Collaboration Regional meetings sponsored by ACF during 2005. These meetings brought together Directors from Child Support Enforcement, Child Welfare, Medicaid, and SCHIP from each State along with Federal, Central and Regional Office representatives to collaborate on ways to increase medical support for children.

**Report:**

A-01-03-02502 (final report, 5/05)

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## Ability of Noncustodial Parents To Contribute Towards Their Children's Medicaid Costs

**Current Law:** Current regulations require the State Title IV-D agency to petition the court or administrative authority, unless the custodial parent and children have satisfactory health insurance other than Medicaid, to include health insurance that is available to the noncustodial parent at reasonable cost in new or modified orders for support. In addition, State Medicaid agencies are required to take reasonable cost-effective measures to determine the legal liability of third parties, including noncustodial parents, to pay for Medicaid services. Finally, section 1912(b) of the Social Security Act allows States to recover Medicaid costs from individuals.

**Proposal (✓Procedural, ✓Legislative):** ACF and CMS should (1) provide specific guidance to States on collecting Medicaid costs from noncustodial parents who have the financial ability to pay or who do not have affordable employer-sponsored health coverage available, (2) clarify third-party liability regulations to assist State Medicaid agencies in coordinating with State Title IV-D agencies to collect Medicaid costs from noncustodial parents with medical support orders, and (3) seek legislation that would allow States to accumulate medical support payments to offset Medicaid fee-for-service costs for a reasonable period.

**Reason for Action:** States can reduce State and Federal Medicaid costs by increasing the number of noncustodial parents who provide medical support for their children. While Federal regulations authorize States to recover Medicaid costs from third-party payers: (1) Title IV-D regulations do not provide specific guidance for collecting Medicaid costs from noncustodial parents who have the financial ability to pay and who do not have affordable employer-sponsored health coverage available; (2) Medicaid third-party liability regulations do not address how State Medicaid agencies should coordinate with State Title IV-D; and (3) Medicaid regulations do not address how the States should establish and administer Medicaid fee-for-service recoveries.

### Savings (in Millions):

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
\$99*	TBD*	TBD*	TBD*	TBD*

*\*The FY1 estimate is based on our review of eight States. We did not quantify savings for future years.*

**Status:** In 2005, CMS provided guidance to States on the collection of Medicaid costs from available noncustodial employer-sponsored health care coverage through a series of meetings sponsored by ACF. State Directors from Child Support Enforcement, Child Welfare, Medicaid, SCHIP and Federal representatives met to discuss ways to increase medical support for children. Follow up meetings are scheduled for 2006. The President's FY 2007 Budget proposes an amendment relating to payment of third party claims involving medical child support. The Budget would extend to 90 days (from 30) before a State is required to make payment on these claims and seek reimbursement from responsible noncustodial parents.

### Report:

A-01-03-02501 (final report, 6/05)

# Medicaid Drug Reimbursement

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## Omission of Drugs From the Federal Upper Limit List in 2001

**Current Law:** Pursuant to 42 CFR § 447.332, CMS is authorized to establish Federal upper limits (FUL) to limit the amount Medicaid can reimburse for multiple-source drugs. These reimbursement limits were established to ensure that Medicaid acts as a prudent payer by taking advantage of current market prices for multiple-source drugs. Regulations set the FUL amount at 150 percent of the published price for the least costly therapeutically-equivalent product that can be purchased in quantities of 100 tablets or capsules plus a reasonable dispensing fee. If the drug product is not available in quantities of 100 or if the drug is a liquid, then the FUL amount should be based on a commonly listed size.

**Proposal (✓Procedural):** CMS should take steps to ensure that all drugs meeting the criteria set forth in Federal laws and regulations are included on the FUL list.

**Reason for Action:** Ninety drug products that met the established criteria were not included on the Federal upper limit list in 2001. If 55 of these drug products had been included on the Federal upper limit list, the Medicaid program could have saved about \$123 million in 2001.

**Savings (in Millions):**

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

**Status:** CMS did not concur with our findings stating that our work did not follow the same procedures CMS uses when establishing the FUL, and included drugs for which a FUL is irrelevant (i.e., the FUL exceeds the average wholesale price). Effective January 1, 2007, the Deficit Reduction Act of 2005 sets the FUL on Medicaid drug payment at 250 percent of the lowest Average Manufacturers Price (AMP) for a generic version of a drug and changes the criteria for drugs added to the FUL. The FY 2007 President's Budget proposes to limit reimbursement for multiple source drugs to 150 percent of AMP. CMS will still need to ensure that qualified drugs are added to the FUL in a timely manner.

**Report:**

OEI-03-02-00670 (final report, 2/04)

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## Addition of Qualified Drugs to the Medicaid Federal Upper Limit List

**Current Law:** Pursuant to 42 CFR § 447.332, CMS is required to establish Federal upper limits in order to reduce the amount that Medicaid reimburses for multiple-source drugs. These regulations instruct CMS to include a drug on the Federal upper limit list if the Food and Drug Administration (FDA) rates at least three versions of the drug as therapeutically equivalent, and the drug has at least three suppliers listed in national compendia. The Deficit Reduction Act provides that Federal upper limits apply to multiple source drugs for which the FDA has rated two or more products to be therapeutically and pharmaceutically equivalent.

**Proposal (✓Procedural):** CMS should establish an administrative procedure and schedule to govern the determination and publication of Federal upper limits.

**Reason for Action:** CMS does not consistently add qualified drugs to the Federal upper limit list in a timely manner. Of the 252 first-time generic drugs approved between January 2001 and December 2003, 109 products met the statutory and regulatory criteria for inclusion. However, only 25 were actually added. It is estimated that Medicaid lost \$167 million between 2001 and 2003 because qualified drugs were not added to the Federal upper limit list in a timely manner.

**Savings (in Millions):**

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
\$167	\$167	\$167	\$167	\$167

**Status:** CMS concurred with the intent of our recommendation and has taken steps to support this objective. However, CMS did not concur with our methodology in performing this review and savings estimates. Effective January 1, 2007, the Deficit Reduction Act will change the criteria for drugs added to the FUL. However, CMS will still need to ensure that qualified drugs are added to the FUL in a timely manner.

**Report:**

OEI-03-04-00320 (final report, 12/04)

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## Variation in State Medicaid Drug Prices

**Current Law:** Under section 1902(a)(30)(A) of the Social Security Act, CMS has the authority to establish methods and procedures to assure that Medicaid payments are consistent with efficiency, economy, quality of care and sufficient provider participation. As part of those efforts, CMS sets upper payment limits for services available under the Medicaid program, including maximum drug reimbursement limits. These upper payment limits are designed to ensure that Medicaid acts as a prudent purchaser of drugs. Within these parameters, each State determines its own pharmacy reimbursement formula(s).

**Proposal (✓Procedural):** CMS should share additional drug pricing information with States, conduct further research on the factors that affect States' drug prices, and annually review States' reimbursement data to target technical assistance to higher paying States.

**Reason for Action:** We found that the highest paying State's unit reimbursement price ranged from 12 to 4,073 percent more per drug than the lowest paying State for 28 drugs. Medicaid could have saved an estimated \$86.7 million in fiscal year 2001 if all States had reimbursed at the same price as the lowest paying State for each of the 28 drugs. States' drug prices are derived from multiple factors and vary even among States with the same pharmacy reimbursement formula.

**Savings (in Millions):**

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
\$86.7	\$86.7	\$86.7	\$86.7	\$86.7

**Status:** CMS did not concur with the report due to concerns about data. For example, CMS had concerns about the magnitude of the price variation and that the prices paid by the highest paying States for certain drugs are above the Federal upper payment limits.

**Report:**

OEI-05-02-00681 (final report, 9/04)

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## Reemphasize to States the Requirements of the Medicaid Drug Rebate Program with Regard to Accurate and Reliable Information and the Billing and Collecting of Rebates

**Current Law:** The Omnibus Budget Reconciliation Act of 1990 established the Medicaid drug rebate program to allow Medicaid to receive pricing benefits commensurate with its position as a high-volume purchaser of prescription drugs. Section 1927 of the Social Security Act requires drug manufacturers to enter a rebate agreement with CMS to participate in the Medicaid program. The manufacturer must submit a listing to CMS of all covered outpatient drugs and report quarterly its average manufacturer price and best price for each drug. Federal regulations (45 CFR § 74.21(b)(3)) require that financial management systems provide for effective control and accountability for all funds, property, and other assets.

**Proposal (✓Procedural):** CMS should reemphasize the requirement that States submit accurate and reliable information on their quarterly Medicaid drug rebate reports and emphasize to States their need to place a priority on their billing and collecting of drug rebates.

**Reason for Action:** In 45 of 49 States and the District of Columbia, our audits identified weaknesses in accountability and internal controls over their drug rebate programs. As a result, States lacked adequate assurance that all drug rebates due the States were properly recorded, and/or collected. Additionally, CMS did not have reliable information to properly monitor the drug rebate program.

**Savings (in Millions):**

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

**Status:** CMS agreed with the recommendations. The recommendations were addressed by State Medical Director Letter SMDL #05-005, dated December 22, 2005, which specifically references the accuracy of data on the HCFA-64 (Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program).

**Report:**

A-06-03-00048 (final report, 7/06)

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## Previous Recommendations

## End Stage Renal Disease

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

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

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

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

**Savings (in Millions):**

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

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

**Report:**

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

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## Reduce Medicare End Stage Renal Disease Payment Rates

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

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

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

**Savings (in Millions):\***

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

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

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

**Report:**

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

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## Reduce the Epogen Reimbursement Rate

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

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

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

**Savings (in Millions):**

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

**Status:** CMS agreed and the Benefits Improvement and Protection Act of 2000 required the Secretary to develop a composite rate that includes, to the extent feasible, payment for laboratory tests and drugs that are routinely used in dialysis treatments but are now separately billable. The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 requires the Secretary to establish a case-mix adjusted Composite Rate for 2005 and conduct a demonstration of a bundled case-mix adjusted prospective payment system. The MMA directs CMS to use the results of one of our studies on separately billable end state renal disease drug payments and costs to set the 2005 Composite Payment Rate. Section 623 of the MMA requires that beginning January 1, 2005, payment for Epogen (as well as other end stage renal disease drugs) will be based on acquisition costs. Effective January 1, 2006, Epogen will be based on average sales price plus 6 percent.

**Report:**

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

# Durable Medical Equipment

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## Reduce Medicare Part B Payments for Power Wheelchairs

**Current Law:** Medicare Part B classifies certain items of durable medical equipment, such as power wheelchairs, as capped rental items. Medicare pays for the rental of these items for a period of continuous use not to exceed 13 months. Beneficiaries have the option of purchasing a power wheelchair within the first month of use.

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

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

**Savings (in Millions):**

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

**Status:** CMS has changed much of the infrastructure related to power wheelchair coverage and payment including: issuing a new National Coverage Determination which replaces the historical “bed or chair confined” standards, eliminating the Certificate of Medical Necessity, proposing a new coding system for power wheelchairs that outlines the particular features of the specific equipment supplied, implementing MMA provisions that expand the types of health professionals who may order certain types of power mobility devices, requiring a face-to-face examination of the patient, and moving toward a competitive bidding system for suppliers. CMS has been working with local DME contractors on preparing educational materials for physicians and suppliers related to changes concerning coverage and reimbursement. CMS also indicated that it will work with the DME contractors to carefully monitor billing trends to identify extraordinary situations where further intervention is warranted to ensure that claims are submitted accurately and that coverage decisions are appropriate.

**Report:**

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

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## Improve Compliance With Medicare Coverage Criteria for Power Wheelchairs

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

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

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

**Savings (in Millions):**

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

**Status:** CMS has changed much of the infrastructure related to power wheelchair coverage and payment including: issuing a new National Coverage Determination replacing the historical “bed or chair confined” standards, eliminating the Certificate of Medical Necessity, proposing a new coding system for power wheelchairs that outlines the particular features of the specific equipment supplied, implementing MMA provisions that expand the types of health professionals who may order certain types of power mobility devices, requiring a face-to-face examination of the patient, and moving toward a competitive bidding system for suppliers. CMS has been working with local DME contractors on preparing educational materials for physicians and suppliers related to changes concerning coverage and reimbursement. CMS also indicated that it will work with the DME contractors to carefully monitor billing trends to identify extraordinary situations where further intervention is warranted to ensure that claims are submitted accurately and that coverage decisions are appropriate.

**Report:**

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

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## Reduce Medicare Part B Payments for Enteral Nutrition at Home

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

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

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

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

**Savings (in Millions):**

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

**Status:** CMS concurred with our recommendation, but must wait to initiate inherent reasonableness reviews until written procedures for conducting these reviews are developed according to statute and regulation. In accordance with the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, competitive acquisition of enteral nutrition will be phased in beginning in 2007.

**Reports:**

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

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

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

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

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

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

**Savings (in Millions):**

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

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

**Report:**

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

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## Prevent Medicare Losses Resulting From Early Payments for Medical Equipment

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

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

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

**Savings (in Millions):**

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

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

**Report:**

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

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

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

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

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

**Savings (in Millions):**

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

**Status:** CMS concurred with our recommendation and has developed a Common Working File record that identifies those beneficiaries who are admitted to SNFs and denies payment for DME during SNF stays.

**Report:**

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

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## Eliminate Semiannual Maintenance Payments for Capped Rental Equipment

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

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

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

**Savings (in Millions):**

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

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

**Report:**

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

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## Adjust Reimbursement for Semielectric Hospital Beds

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

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

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

**Savings (in Millions):**

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

**Status:** CMS concurred with our recommendations but is waiting to initiate inherent reasonableness reviews pending development of written procedures for conducting these reviews. In accordance with the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the Medicare fee schedule amounts for semielectric hospital beds were reduced by an average of 13.5 percent effective January 1, 2005.

**Report:**

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

# Medicare Managed Care

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## Modify Payments to Managed Care Organizations

**Current Law:** The Balanced Budget Act of 1997 established the Medicare+Choice program with the primary goal of providing a wider range of health plan choices to Medicare beneficiaries. The Act also modified the payment methodology under the program to correct excess payments, reduce geographic variations in payments, and align payments to reflect beneficiaries' health status. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 redesignated the M+C program as Medicare Advantage and increased payments, including a provision to the payments to Medicare outlays in fee-for-service sector.

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

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

**Savings (in Millions):**

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

**Status:** Subsequent legislation to the BBA of 1997 increased payments to MAOs. However, we still have concerns that the Federal payment to MAOs is excessive because the 1997 base rate was flawed. We will be updating our work to examine MAO payments as a result of all legislative changes.

**Report:**

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

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## Monitor Managed Care Organizations' Rate Proposals

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

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

**Reason for Action:** Our reviews of 186 proposals submitted by 55 MAOs for calendar year 2000 found that:

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

**Savings (in Millions):**

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

**Status:** CMS generally concurred with the recommendations. However, CMS had concerns with the methodology we used in calculating the impact on Medicare beneficiaries from overcharges and/or forfeited additional benefits. Under provisions of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, if the monthly Medicare payments amount exceeds the monthly bid amount, 75 percent of the resultant savings will be given to the beneficiary in the form of additional benefits and/or reduced premiums with the remaining 25 percent retained by the Federal Government. Thus, the accuracy of the underlying cost assumptions in the bid proposals will affect Federal funds.

**Report:**

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

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

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

**Proposal (✓*Legislative*, ✓*Procedural*):** CMS should institute a reasonable ceiling on the administrative costs permitted in an MAO proposal.

**Reason for Action:** As a percentage of the total rate proposed, the administrative rate varied widely among MAOs reviewed, regardless of the type of MAO (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. In addition, our reviews of the administrative costs included in the 1997 proposals submitted by nine MAOs found that \$66.3 million of the actual administrative costs incurred would have been recommended for disallowance had they been required to follow Medicare's general principle of paying only reasonable costs. In a subsequent review of 10 MAOs' proposals for 2000, we found that \$97.1 million in base-year administrative costs would have been recommended for disallowance had the MAOs been required to follow Medicare's general principle of paying only reasonable costs.

**Savings (in Millions):**

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

**Status:** We will be updating our work to examine administrative costs under provisions of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. CMS did not agree with our recommendation to institute a ceiling on the administrative costs included in MAO proposals.

**Reports:**

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

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

## Other Medicare Reimbursement

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### Encourage Least Costly Alternative Policies for Lupron Reimbursement

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

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

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

**Savings (in Millions):**

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

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

**Report:**

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

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## Reduce Medicare Payments to Ambulatory Surgical Centers for Intraocular Lenses

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

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

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

**Savings (in Millions):**

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

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

**Report:**

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

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

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

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

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

**Savings (in Millions):**

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

**Status:** The regional home health intermediaries generally agreed with our recommendations. CMS has instructed them to collect the overpayments. In April 2004, CMS implemented prepayment edits and postpayment claims data analysis to prevent and detect overpayments. We are continuing our work to identify additional overpayments that occurred prior to the implementation of the edits.

**Reports:**

A-01-03-00500 (final report, 7/03)  
A-04-03-00018 (final report, 2/04)  
A-09-03-00042 (final report, 2/04)  
A-07-03-04021 (final report, 3/04)

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## Change the Way Medicare Pays for Clinical Laboratory Tests

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

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

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

### Savings (in Millions):

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

*This savings estimate would result from the copayment; the saving estimate for fee schedule adjustments has yet to be determined.*

**Status:** CMS has taken corrective actions to reduce payments for laboratory services. A proposal to reduce payment updates from FY 2003 through 2005 was included in the President’s FY 2001 budget, as well as was a proposal to reinstate laboratory cost sharing. Neither of these proposals was enacted. In addition, the Balanced Budget Act of 1997 required the Secretary to request that the Institute of Medicine conduct a study of Part B laboratory test payments. As of result of the Institute of Medicine’s recommendations, the MMA mandated that CMS conduct a demonstration that applies competitive bidding to clinical laboratory services. The initial report was due to Congress by December 31, 2005. The MMA also set the laboratory fee schedule updates at 0 percent for 2004 through 2008.

### Reports:

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

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

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## Adjust Home Health Agency Prospective Payments

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

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

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

**Savings (in Millions):**

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

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

**Report:**

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

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## Require Physician Examination Before Ordering Home Health Services

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

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

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

**Savings (in Millions):**

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

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

**Reports:**

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

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

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

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

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

### Savings (in Millions):

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

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

### Reports:

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

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

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

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## Eliminate Overpayments Under Consolidated Billing by Skilled Nursing Facilities

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

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

**Reason for Action:** For over one-third of the claims examined in our pilot review, we found that Medicare contractors made separate Part B payments to outside suppliers for services that were subject to consolidated billing. These services were included in the prospective payments that Medicare made to the skilled nursing facilities. As a result, the Medicare program paid twice for the same service—once to the nursing facility under the Part A prospective payment and again to the outside supplier under Part B. Our subsequent nationwide reviews identified \$149 million in potentially improper Medicare payments during calendar years 1999 and 2000 for services that were subject to consolidated billing.

**Savings (in Millions):**

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
\$74.5	\$74.5	\$74.5	\$74.5	\$74.5

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

**Reports:**

- A-01-99-00531 (final report, 3/00)
- A-01-00-00538 (final report, 6/01)
- A-01-02-00513 (final report, 5/04)

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## 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 services, to be reasonable and necessary for the diagnosis or treatment of an illness or injury.

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

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

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

### **Savings (in Millions):\***

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

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

**Status:** Concurring with the individual reports, CMS has initiated some efforts, particularly regarding community mental health centers. Reviews are ongoing at additional Community Mental Health Centers and at fiscal intermediaries. We currently are reviewing this area to determine if substantial errors are still present.

### **Reports:**

A-04-98-02145 (final report, 10/98)	OEI-02-99-00140 (final report, 1/01)
A-01-99-00507 (final report, 3/00)	OEI-03-99-00130 (final report, 5/01)
A-01-99-00530 (final report, 12/00)	

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## Conduct Medical Reviews of Part B Therapy Services

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

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

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

**Savings (in Millions):**

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

**Status:** CMS instructed its contractors to concentrate their efforts on random reviews of all claims and planned to use the results of those reviews to focus additional efforts. The Balanced Budget Refinement Act of 1999 required the Secretary to conduct focused medical reviews of therapy services during 2000 and 2001. Using Medicare Integrity Program funds, CMS awarded a contract for the Therapy Review Program, a study of the utilization of therapy services. The Therapy Review Program confirms that therapy services were often billed incorrectly. Contractors have continued to use data analysis tools and techniques to identify potential improper payments. The November 2005 Comprehensive Error Rate Testing (CERT) report continued to indicate that physical therapists, occupational therapists, and physical medicine specialists continue to bill improperly. Contractors will use CERT findings to continue to refine their medical review and education interventions to target providers and provider types posing risks to the Medicare program.

**Reports:**

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

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## Ensure the Medical Necessity of Ambulance Claims

**Current Law:** Medicare covers and pays for emergency and nonemergency ambulance transports when a beneficiary’s medical condition, at the time of transport, is such that other means for transportation, such as taxi, private care, wheelchair van, or other type of vehicle, would jeopardize the beneficiary’s health. Ambulance transport must be reasonable and medically necessary.

**Proposal (✓Procedural):** CMS should implement program integrity activities designed to reduce improper payments for ambulance transports at greatest risk of error.

**Reason for Action:** We conducted this study as a followup to previous work that identified high payment error rates for ambulance transports. This study indicated that 25 percent of ambulance transports did not meet Medicare’s program requirements, resulting in an estimated \$402 million of improper payments.

**Savings (in Millions):\***

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
\$402	\$402	\$402	\$402	\$402

**Status:** CMS concurred with our recommendation. CMS indicated that it will advise all contractors to consider implementing prepayment edits for trips with an origin or destination modifier for a dialysis facility, as well as nonemergency transports to and from a hospital, nursing home, or physician’s office. In addition, CMS will encourage contractors to consider obtaining documentation for ambulance supplier and third party providers to determine that ambulance transports meet program requirements on post-payment review and educating supplier and third party providers who initiate ambulance transports about the appropriate use of Medicare’s nonemergency ambulance transport benefit.

**Reports:**

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

OEI-05-02-00590 (final report, 1/06)

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

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

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

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

**Savings (in Millions):**

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

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

**Report:**

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

# Medicaid Reimbursement

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## Declare That Medicaid Payments Returned by Public Providers Are Refunds

**Current Law:** Since the inception of the Medicaid program, the Federal Government and the States have shared in its costs. States pay medical providers who furnish care and services to Medicaid-eligible individuals. The Federal Government pays the States its share of these medical assistance payments according to a defined formula, which yields the Federal medical assistance percentage. This percentage ranges from 50 percent to 76 percent, depending on the State's per capita income.

**Proposal (✓*Legislative*):** CMS should propose legislation to require that Medicaid payments returned by public providers to the State are declared a refund to be used to offset or credit the Federal financial participation generated by the original payment. Congress did not act on the President's FY 2006 legislative proposal that would have accomplished this goal.

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

**Savings (in Millions):**

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

**Status:** In April 2004, CMS testified before the House Energy and Commerce Committee and indicated that it supports declaring these returned funds as credits or refunds to offset the original State payment. The Federal share would then be calculated based on the net Medicaid payment retained by the provider. The President's FY 2007 Budget proposes an administrative change that builds on past CMS efforts to curb questionable financing practices by (1) recovering Federal funds that are diverted from government providers and retained by the State and (2) capping payments to government providers to no more than the cost of furnishing services to Medicaid beneficiaries.

**Report:**

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

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

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

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

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

**Savings (in Millions):**

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

**Status:** CMS partially concurred with our recommendations. CMS agreed that it should provide more guidance to the States on calculating the upper payment limit. In addition, the President's FY 2006 budget proposed a legislative change that would limit reimbursement levels to government providers to no more than the cost of providing services.

**Report:**

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

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## Address and Resolve Excessive Medicaid Disproportionate Share Hospital Payments

**Current Law:** Section 1923 of the Social Security Act (the Act), as amended by the Omnibus Budget Reconciliation Act of 1993, requires that States make Medicaid disproportionate share hospital (DSH) payments to hospitals that serve disproportionate numbers of low-income patients with special needs. Section 1923(g) of the Act limits these payments to a hospital's uncompensated care costs, which are the annual costs incurred to provide services to Medicaid and uninsured patients less payments received for those patients.

**Proposal (✓Regulatory, ✓Procedural):** CMS should ensure resolution of the monetary recommendations to individual States regarding DSH payments that exceeded the hospital-specific limits. CMS should establish regulations requiring States to (1) implement procedures to ensure that future DSH payments are adjusted to actual incurred costs, (2) incorporate these procedures into their approved State plans, and (3) include only allowable costs as uncompensated care costs in their DSH calculations. CMS should strengthen its review and approval of State plans to ensure consistency with Federal requirements and use results of audits conducted under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 in its review process.

**Reason for Action:** Nine of the ten States reviewed did not comply with the hospital specific DSH limits imposed by section 1923(g) of the Act. As a result, payments exceeded the hospital-specific limits by about \$1.6 billion (\$902 million Federal share). About \$679 million of the total \$902 million in payments were based on historical costs. States did not later adjust the payments using actual costs. States also made excess payments because they included unallowable costs in their calculations of hospital-specific limits. About \$151 million of the unallowable costs consisted of costs for institutions for the treatment of mental diseases and nonhospital services, and about \$72 million was for various unallowable costs such as bad debts, miscalculations, and other accounting errors. In addition, three States required hospitals to return DSH payments totaling approximately \$3.6 billion through intergovernmental transfers.

### Savings (in Millions):

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

### Status:

CMS is recovering overpayments from individual States and developing a DSH program regulation. The President's FY 2007 Budget proposes an administrative change to limit Federal reimbursement to government providers to no more than cost.

### Reports:

A-06-00-00058 (final report, 6/01)	A-03-01-00226 (final report, 5/03)
A-06-00-00026 (final report, 6/01)	A-09-02-00054 (final report, 5/03)
A-07-01-02089 (final report, 5/02)	A-09-02-00071 (final report, 5/03)
A-07-01-02093 (final report, 8/02)	A-05-01-00087 (final report, 3/04)
A-09-01-00098 (final report, 9/02)	A-04-01-02006 (final report, 6/04)

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## Ensure Compliance With Requirements for Medicaid School-Based Health Services

**Current Law:** Section 1903(c) of the Social Security Act was amended in 1988 to allow Medicaid payment of covered services for children under the Individuals with Disabilities Education Act. The Act requires States to provide appropriate special education and related services to children with disabilities or special needs.

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

**Reason for Action:** Our reviews identified Medicaid overpayments for school-based health services. The Federal share of the overpayments totaled an estimated \$800 million. Many of the services claimed lacked a referral by an appropriate medical professional or were not provided by or under the direction of a qualified speech-language pathologist. These unallowable claims generally occurred because States did not provide sufficient guidance to and oversight of local education agencies, and rates were not developed in accordance with applicable Federal cost allocation requirements or CMS program guidelines.

### Savings (in Millions):

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

**Status:** CMS has begun taking action in individual States to recover overpayments. CMS has recently undertaken a significant effort to bring State plans into compliance with Federal law, regulations, and policy in the coverage areas that pertain to Medicaid services delivered in school settings. The President's FY 2007 Budget proposes to prohibit Federal Medicaid reimbursement for school-based administrative or transportation costs.

### Reports:

A-04-00-02161 (final report, 11/01)	A-01-02-00006 (final report, 5/03)
A-10-01-00011 (final report, 5/02)	A-01-02-00009 (final report, 7/03)
A-01-01-00006 (final report, 5/02)	A-02-03-01008 (draft report, 7/03)
A-10-01-00006 (final report, 8/02)	A-10-02-00008 (final report, 7/03)
A-06-01-00077 (final report, 10/02)	A-05-02-00049 (final report, 12/03)
A-02-02-01018 (final report, 12/02)	A-06-02-00037 (final report, 1/04)
A-03-01-00224 (final report, 3/03)	A-01-02-00014 (final report, 2/04)
A-04-01-00005 (draft report, 3/03)	A-02-02-01030 (final report, 2/04)
A-05-02-00023 (final report, 3/03)	A-07-02-02099 (final report, 2/04)
A-02-02-01022 (final report, 4/03)	A-06-01-00083 (final report, 4/03)
A-01-02-00016 (final report, 9/04)	A-01-03-00004 (final report, 1/05)
A-01-04-00004 (final report, 1/05)	A-07-03-00154 (final report, 4/05)
A-02-02-01029 (final report, 6/05)	A-05-02-00050 (final report, 8/05)

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

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

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

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

**Savings (in Millions):**

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

**Status:** CMS did not concur with our recommendation. According to CMS, the transition periods were established pursuant to either notice-and-comment rulemaking or legislation, and offering new proposals at this time would undermine the consensus reached through those processes. CMS anticipates no further action on our recommendation. Five States remain with transition periods through September 1, 2008.

**Report:**

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

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

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

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

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

**Savings (in Millions):**

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

**Status:** CMS concurred with our recommendation and is working with States to review their estimates of acquisition costs in light of our findings. In addition, the President's FY 2006 budget proposed a legislative change that would limit the Federal reimbursement to States for Medicaid pharmacy payments to the amount the State would have paid, in the aggregate, for covered outpatient drugs based on the manufacturers average sales price. We will continue to monitor the pricing of Medicaid drug reimbursements for brand name drugs.

**Reports:**

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

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

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

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

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

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

**Savings (in Millions):**

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

**Status:** CMS concurred with our recommendation. The agency is working with States to strongly encourage them to review their estimates of acquisition costs and will follow up to ensure that they take our findings into account. In addition, the President's FY 2006 budget proposed a legislative change that would limit the Federal reimbursement to States for Medicaid pharmacy payments to the amount the State would have paid, in the aggregate, for covered outpatient drugs based on the manufacturers average sales price. We will continue to monitor the pricing of Medicaid drug reimbursements for generic drugs.

The Deficit Reduction Act of 2005 (DRA) changes the Medicaid reimbursement rate for drugs to make payments more accurate. For generic drugs the Federal Government will set a FUL on Medicaid drug payment that is equal to 250 percent of the lowest average manufacturer's price (AMP) for a generic version of a drug. According to the DRA, AMP has been redefined as the average price at which manufacturers sell their drugs to wholesalers.

The FY 2007 President's Budget proposes to build on the DRA changes to the FUL for multiple source drugs. The Budget proposes to limit reimbursement for multiple source drugs to 150 percent of AMP.

**Reports:**

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

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

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

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

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

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

**Savings (in Millions):\***

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

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

**Status:** CMS agreed to pursue a change in the Medicaid drug rebate program similar to that recommended. No changes have yet been made. However, committees in both the Senate and House have proposed language establishing a better connection. In addition, the President's FY 2007 Budget proposes to eliminate best price and revise the rebate percentage, in a budget neutral manner, to help offset the cost.

**Report:**

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

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

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

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

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

**Savings (in Millions):**

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

**Status:** CMS disagreed with this recommendation. We are continuing to monitor the drug rebate program; audits will continue to focus on enhancing the collection of rebates and providing potential savings to the rebate program. We have issued rebate reports to each State Medicaid agency as it relates to the State's internal control.

**Report:**

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

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

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

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

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

**Savings (in Millions):**

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

**Status:** CMS agreed with the recommendation and has worked to improve its oversight of the cost avoidance waiver process. This was discussed with CMS’s Regional Offices in February 2005 to assess whether States are appropriately paying and chasing claims. In addition, CMS provided training for staff to ensure that appropriate cost avoidance waiver criteria are being applied in granting any such waivers. Also, CMS is currently planning to survey and update State progress in cost avoiding several major claim types. The President’s FY 2007 Budget proposes to discontinue all waivers that permit pay and chase of pharmacy claims.

**Reports:**

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

# Hospitals

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## Continue Mandated Reductions in Hospital Capital Costs

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

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

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

**Savings (in Millions):**

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

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

**Reports:**

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

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

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

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

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

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

**Savings (in Millions):**

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

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

**Report:**

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

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## Collect Overpayments for Prospective Payment System Transfers Incorrectly Reported as Discharges

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

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

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

**Savings (in Millions):**

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

**Status:** CMS concurred with our recommendation to collect potential overpayments but stated that it would initially limit the recovery effort to the last 4 years to comply with the cost report reopening period designated in 42 CFR 405.750. In September 2001, CMS advised the intermediaries to recover overpayments on the claims we identified that were 4 years old or less from the date of initial determination (bill processing date). As of February 14, 2005, 37 intermediaries reported recoveries totaling \$23.3 million.

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

**Report:**

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

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

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

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

**Savings (in Millions):**

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

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

**Report:**

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

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## Revise Graduate Medical Education Payment Methodology

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

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

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

### Savings (in Millions):

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

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

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

### Report:

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

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## Modify Payment Policy for Medicare Hospital Bad Debts

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

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

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

**Savings (in Millions):\***

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

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

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

**Report:**

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

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## Prevent Overpayments Under Medicare’s Postacute Care Transfer Policy

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

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

**Reason for Action:** We estimated that between fiscal years 1999 and 2002, the Medicare program paid approximately \$188.4 million in excessive payments to prospective payment system hospitals as a result of these erroneously coded discharges. Our reviews indicated that the Common Working File had no controls or edits in place to prevent excessive payments to such hospitals for erroneously coded qualified discharges that are followed by postacute care.

**Savings (in Millions):**

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
\$47.1	\$47.1	\$47.1	\$47.1	\$47.1

**Status:** CMS concurred with our recommendations. Subsequent to our audit period, CMS implemented edits. We will continue our work to identify additional overpayments that occurred prior to the implementation of the edits and to ensure that the edits are working properly.

**Reports:**

- A-04-00-01210 (final report, 12/00)
- A-04-00-02162 (final report, 2/01)
- A-04-00-01220 (final report, 10/01)
- A-04-02-07005 (final report, 4/03)
- A-04-04-03000 (final report, 4/05)

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## Recover Overpayments and Expand the Diagnosis-Related Group Payment Window

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

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

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

### Savings (in Millions):

Diagnostic services provided:

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

*\*For 10 selected DRGs.*

**Status:** CMS concurred with our recommendation; however, CMS noted that some additional factors would have to be considered before a legislative change could be advanced.

### Reports:

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

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

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## 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 claims data and the most recent available cost report data to develop the rates.

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

**Reason for Action:** We are concerned about the reliability of the claims 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. Because the prospective payment fee schedules and expenditure ceiling are based on prior Medicare outpatient reimbursement, we believe that the rates may be inflated and that hospitals will realize windfall profits at Medicare's expense.

**Savings (in Millions):**

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

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

**Report:**

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

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## Establish More Consistent Outpatient Surgery Rates That Reflect Only Necessary Costs

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

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

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

### **Savings (in Millions):**

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

**Status:** CMS agrees to consider seeking authority to set rates that are consistent across sites as it develops its legislative program. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 requires CMS to implement a revised payment system for ASCs between January 2006 and January 2008.

CMS published the Medicare Program; Updated ASC List of Covered Procedures (IFC) on May 4, 2005. Several of the procedures recommended to be deleted were retained because commenters identified circumstances that clinically required the procedures to be performed in a facility setting rather than a physician's office.

### **Reports:**

A-14-89-00221 (final report, 3/91)  
A-14-98-00400 (final report, 11/98)  
OEI-09-88-01003 (final report, 5/89)  
OEI-05-00-00340 (final report, 1/03)

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

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

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

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

**Savings (in Millions):**

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

**Status:** CMS initially agreed with our findings but stated that further analysis would be required before any legislative changes could be supported. No action has been taken on this recommendation. We will consider reviewing this issue when claims data for the new inpatient psychiatric prospective payment system is available.

**Report:**

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

# Administration on Aging

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## Use Voluntary Contributions To Expand Services for the Elderly

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

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

**Reason for Action:** According to their financial status reports, 28 States and the District of Columbia erroneously used \$90.8 million in voluntary contributions in fiscal year (FY) 1996.

**Savings (in Millions):**

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

**Status:** AoA agreed with our recommendation and will review its regulations in response to the outcome of the pending reauthorization of the Older Americans Act.

**Report:**

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

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