Department of Health & Human Services

Office of Inspector General

Cost-Saver Handbook

THE 2001

RED

BOOK

OFFICE OF INSPECTOR GENERAL

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

Office of Audit Services

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

Office of Evaluation and Inspections

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

Office of Investigations

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

Office of Counsel to the Inspector General

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

Introduction to the Red Book

Purpose of the Red Book

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

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

The savings estimates indicated for these unimplemented recommendations are updated from time to time to reflect more current data as it becomes available. The estimates have varying levels of precision. Full implementation of the recommendations in this 2001 edition of the *Red Book* could produce substantial savings to the Department.

Department of Health and Human Services

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

The Department's operating agencies are briefly described below:

- The Health Care Financing Administration (HCFA) administers the Medicare, Medicaid, and State Children's Health Insurance programs.

- The Public Health Service (PHS) agencies include the National Institutes of Health, the Food and Drug Administration, the Centers for Disease Control and Prevention, the Health Resources and Services Administration, the Indian Health Service, the Agency for Toxic Substances and Disease Registry, the Agency for Healthcare Research and Quality, and the Substance Abuse and Mental Health Services Administration. They promote biomedical research and

disease cure and prevention; ensure the safety and efficacy of marketed food, drugs, and medical devices; measure the impact of toxic waste sites on health; and conduct other activities designed to ensure the general health and safety of American citizens.

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

- The Administration on Aging (AoA) serves as an advocate for older persons at the national level.

- General departmental management includes such staff division activities as financial management and grant and contract administration.

Organization of the Red Book

The following sections of the *Red Book* separately address the OIG's recommendations to each of the agencies listed above. Most of these recommendations stem from final reports. Recommendations from draft reports represent the OIG's tentative position and are subject to change when the final versions of the reports are issued.

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

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

We hope that this 2001 edition of the *Red Book* will prove to be a useful asset for departmental decision-makers, the Administration, and the Congress in their continuing efforts to contain costs and improve program efficiency at HHS.

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Health Care Financing Administration

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

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Public Health Service Agencies

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Administration for Children and Families

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General Departmental Management

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HEALTH CARE FINANCING ADMINISTRATION

Health Care Financing Administration

Overview

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

The Medicaid program provides grants to States for medical care for almost 42 million low-income people. Eligibility for Medicaid is, in general, based on the rules in place on July 16, 1996, for the former Aid to Families with Dependent Children program and the rules of the Federal Supplemental Security Income program for the aged, the blind, and the disabled. State expenditures for medical assistance are matched by the Federal Government using a formula that measures per capita income in each State relative to the national average.

Significant OIG Activities

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

The unimplemented OIG recommendations in this *Red Book* that relate to HCFA activities could produce significant annual savings and recoveries to the Department. The OIG has identified a number of significant Medicare policy issues, such as adjusting managed care capitation rates to account for unrecovered improper payments, revising prescription drug payment methods, and reducing reimbursement for hospital capital costs. Regarding Medicaid, the OIG has recommended modifying the formula that determines the Federal share of costs, establishing a more realistic drug rebate, and installing edits to preclude improper payment for laboratory services.

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

Current Law:

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

Proposal:

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

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

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

Savings (in millions):

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

Status:

Although HCFA included a proposal to mandate Medicare coverage for all State and local government employees in the FY 1990 budget submission, no legislative proposal was included in the President's FY 2001 budget. Also, HCFA did not agree with our recommendation to make Medicare the secondary payer, noting, among other things, that this would eventually be more costly for the exempt agencies than mandated coverage.

Report:

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

CONTINUE MANDATED REDUCTIONS IN HOSPITAL CAPITAL COSTS

Current Law:

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

Proposal:

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

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

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

Savings (in millions):

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

Status:

The HCFA did not agree with our recommendation. Although the Balanced Budget Act (BBA) 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 would reduce capital payments and save $630 million in FY 2001 through FY 2005.

Report:

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

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

Current Law:

Under section 1886(d) of the Social Security Act, the Medicare program pays for the operating costs attributable to hospital inpatient services under a PPS. A PPS 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 PPS for capital costs for cost reporting periods beginning in FY 1992.

Proposal:

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

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

While HCFA took care to devise and implement an equitable PPS for capital costs, some future cost items had to be estimated. A few years later, when actual data was available, we compared HCFA'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 HCFA had to make in arriving at an anticipated rate to implement the capital cost PPS. The total effect of overpayments in relation to cost used as the basis for the capital cost PPS will gradually increase from 1996 until the capital cost PPS is fully implemented in 2002.

Savings (in millions):

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

Status:

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

Report:

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

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

Current Law:

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

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

Proposal:

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

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

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

Savings (in millions):

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

Status:

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

Report:

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

REVISE GRADUATE MEDICAL EDUCATION PAYMENT METHODOLOGY

Current Law:

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

Proposal:

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

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

The HCFA estimated that the revised graduate medical education methodology would result in substantial Medicare savings. Our review indicated that Medicare costs under this methodology may 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 the graduate medical education reimbursement. Second, the Medicare patient load percentage used to compute Medicare's share of these costs is based on inpatient data only and is higher than Medicare's overall share of graduate medical education costs as determined under the previous method, which also included ancillary and outpatient data.

Savings (in millions):

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

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

Status:

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

Report:

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

DENY MEDICARE REIMBURSEMENT FOR PATIENTS WHO RECEIVE SUBSTANDARD MEDICAL CARE

Current Law:

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

Proposal:

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

Legislative	Regulatory	Other Administrative
☐	✓	☐

Reason for Action:

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

Savings (in millions):

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

Status:

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

Report:

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

MODIFY PAYMENT POLICY FOR MEDICARE BAD DEBTS

Current Law:

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

Proposal:

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

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

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

Savings (in millions):*

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

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

Status:

Agreeing with our recommendation to include a bad debt factor in the DRG rates, HCFA said that our report should assist the Congress in understanding the rapid growth in hospital bad debts. The Balanced Budget Act of 1997 provided for some reduction of bad debt payments to providers. The President's FY 2001 budget proposes to reduce the percentage (from 55 percent to 45 percent) that Medicare pays hospitals for bad debts. However, additional legislative changes are needed to implement the modifications we recommended.

Report:

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

LIMIT PROSPECTIVE PAYMENT SYSTEM REIMBURSEMENT FOR HOSPITAL ADMISSIONS NOT REQUIRING AN OVERNIGHT STAY

Current Law:

Under the prospective payment system, hospitals are reimbursed for each admission when the patient is discharged based on established rates which are grouped into diagnosis related groups. Current Medicare instructions provide that an admission occurs when it is expected that the patient will occupy a bed and remain overnight. This applies even if the person is later discharged or transferred to another hospital without actually using a hospital bed overnight.

Proposal:

The HCFA should seek legislation to pay for covered services related to 1-day admissions without an overnight stay as outpatient services.

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

Based on Medicare records for 1989, our follow-up review (A-05-92-00006) revealed that the volume of 1-day admissions on a national basis had increased approximately 150 percent over 1985 levels and that Medicare had paid for 179,500 admissions that did not require overnight stays. Many of these cases related to observations after emergency or outpatient services, to surgeries later canceled, or to acute care stays of doubtful necessity. In many cases, documentation revealed that few, if any, services were provided while the patient was an inpatient.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$210	$210	$210	$210	$210

Status:

The HCFA proposed to implement our recommendation through administrative remedies which would designate whether specific services are to be covered and paid for as inpatient or outpatient services. No proposal was included in the President's FY 2001 budget.

Report:

A-05-89-00055 (Final report, July 1989)
A-05-92-00006 (Final report, Jan. 1992)

MORE CLOSELY MONITOR SAME-DAY HOSPITAL READMISSIONS

Current Law:

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

Proposal:

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

Legislative	Regulatory	Other Administrative
☐	☐	☑

Reason for Action:

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

Savings (in millions):

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

Status:

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

Report:

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

RECOVER OVERPAYMENTS AND EXPAND THE DIAGNOSIS RELATED GROUP PAYMENT WINDOW

Current Law:

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

Proposal:

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

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

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

Savings (in millions):

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

Status:

The HCFA did not concur with the recommendation to further expand the payment window. No legislative proposal was included in the President's FY 2001 budget.

Report:

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

REDUCE MEDICARE PAYMENTS FOR HOSPITAL OUTPATIENT SERVICES

Current Law:

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

Proposal:

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

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

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

Savings (in millions):

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

Status:

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

Report:

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

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

Current Law:

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

Proposal:

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

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

We are concerned about the reliability of the claim and cost data HCFA 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 reimbursements for outpatient department services. Since the prospective payment fee schedules and expenditure ceiling are based on prior Medicare outpatient reimbursements, we believe that the rates may be inflated and that hospitals will realize windfall profits at Medicare's expense.

Savings (in millions):

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

Status:

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

Report:

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

PRECLUDE PAYMENT FOR MUTUALLY EXCLUSIVE PROCEDURE CODES FOR HOSPITAL OUTPATIENT SERVICES

Current Law:

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

Proposal:

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

Legislative	Regulatory	Other Administrative
☐	☐	☑

Reason for Action:

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

Savings (in millions):

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

Status:

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

Report:

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

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

Current Law:

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

Proposal:

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

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

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

Savings (in millions):

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

Status:

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

Report:

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

PRECLUDE IMPROPER PAYMENTS TO HOSPITALS FOR HOSPICE BENEFICIARIES

Current Law:

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

Proposal:

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

Legislative	Regulatory	Other Administrative
☐	☐	☑

Reason for Action:

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

Savings (in millions):

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

Status:

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

Report:

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

ELIMINATE PROVIDER-BASED DESIGNATIONS OR IMPROVE MANAGEMENT AND OVERSIGHT

Current Law:

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

Proposal:

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

Legislative	Regulatory	Other Administrative
✓		✓

Reason for Action:

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

Savings (in millions):

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

Status:

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

Report:

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

SELECTIVELY CONTRACT FOR CORONARY ARTERY BYPASS GRAFT SURGERY

Current Law:

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

Proposal:

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

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

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

Savings (in millions):

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

Status:

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

Report:

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

EXPAND NATIONAL LIST OF CHEMISTRY PANEL TESTS

Current Law:

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

Proposal:

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

Legislative	Regulatory	Other Administrative
☐	☐	✓

Reason for Action:

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

Savings (in millions):

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

Status:

The HCFA agreed with 8 of the 10 tests recommended for addition to the list and added 6 of these tests to its carrier manual. The HCFA will periodically review applicable tests and related equipment. Also, although a legislative change was included in the President's 1997 budget, the Congress decided (through the Balanced Budget Act of 1997) to achieve savings through other means, including freezing laboratory payments through 2002 and reducing the national cap to 74 percent of the median of all fee schedules. A legislative proposal to reduce laboratory payments for four tests is included in the President's FY 2001 budget.

Report:

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

ENCOURAGE PHYSICIANS TO USE PAPERLESS CLAIMS

Current Law:

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

Proposal:

The HCFA should:

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

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

Legislative	Regulatory	Other Administrative
✓		✓

Reason for Action:

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

Savings (in millions):

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

Status:

The HCFA concurred with our recommendations. The President's FY 2001 budget proposes to allow an assessment of a $1 fee on each claim not submitted electronically. Also, as part of implementing the Health Insurance Portability and Accountability Act, significant outreach activity to providers will be conducted. The HCFA anticipates that the act's standards will eventually raise physician participation in electronic media claims.

Report:

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

MODIFY MEDICARE INCENTIVE PAYMENTS IN HEALTH PROFESSIONAL SHORTAGE AREAS

Current Law:

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

Proposal:

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

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

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

Savings (in millions):

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

Status:

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

Report:

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

REDUCE MEDICARE END STAGE RENAL DISEASE PAYMENT RATES

Current Law:

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

Proposal:

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

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

The HCFA, with our assistance, accumulated 1985 and 1988 cost data to update the composite rates. 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. We believe that both the 1985 and 1988 audited data justify a decrease in the payment rate.

Savings (in millions):*

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

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

Status:

The HCFA agreed that the composite payment rates should reflect the costs of outpatient dialysis treatment in efficiently operated facilities. While the Omnibus Budget Reconciliation Act of 1990 prohibited HCFA from changing these rates, it mandated a study to determine the costs, services, and profits associated with various modalities of dialysis treatments. A March 1996 study by the Prospective Payment Assessment Commission recommended an increase in the current rates, but HCFA did not believe an across-the-board increase was warranted. The HCFA officials said they would continue to monitor facilities' costs and other factors (including volume, effects of a new wage index, quality of care, and industry growth and profitability) to determine if a payment rate increase would be appropriate. Toward this end, the Balanced Budget Act of 1997 required the Secretary to audit the cost reports of each renal dialysis provider at least once every 3 years. The HCFA does not believe that these audits will produce a recommendation to decrease composite payment rates and estimates that the audits may reduce the average facilities' costs by less than 5 percent. The HCFA planned to begin these audits in FY 1999. Section 222 of the BBA 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, and for services during 2001 by 1.2 percent above the payment for services provided on December 31, 2000.

Report:

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

REDUCE THE EPOGEN REIMBURSEMENT RATE

Current Law:

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

Proposal:

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

Legislative	Regulatory	Other Administrative
✓	✓	

Reason for Action:

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

Savings (in millions):

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

Status:

The President's FY 2001 budget proposes to reduce Medicare's reimbursement for Epogen.

Report:

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

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

Current Law:

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

Proposal:

The HCFA should ensure that claims meet Medicare coverage guidelines.

Legislative	Regulatory	Other Administrative
☐	☐	✓

Reason for Action:

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

Savings (in millions):

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

Status:

The HCFA concurred with our recommendation. The HCFA issued a regulation January 25, 1999, which addressed ambulance payment issues and required physician certification of nonemergency transports. However, payments for this group of beneficiaries are particularly problematic; we plan to conduct additional analytical work on this topic.

Report:

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

MODIFY PAYMENT PRACTICES OF AMBULANCE SERVICES FOR MEDICARE END STAGE RENAL DISEASE BENEFICIARIES

Current Law:

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

Proposal:

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

Legislative	Regulatory	Other Administrative
✓	✓	

Reason for Action:

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

Savings (in millions):

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

Status:

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

Report:

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

LIMIT MEDICARE PART B REIMBURSEMENT FOR HOSPITAL BEDS

Current Law:

Medicare Part B covers the rental of medically necessary hospital beds used in the home when prescribed by a physician. Monthly rental payments are made according to a fee schedule established by the Omnibus Budget Reconciliation Act of 1987. Medicare payments are capped at 120 percent of the allowed fee schedule amount over a maximum 15-month period.

Proposal:

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

Legislative	Regulatory	Other Administrative
✓		✓

Reason for Action:

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

Savings (in millions):

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

Note: These savings are not additive.

Status:

The HCFA concurred with our recommendations and is considering options to determine the best approach to achieve a fair price for hospital beds. The agency is examining payment allowances and methodologies at other payers and is reviewing data to determine if Medicare payments are excessive. However, the Balanced Budget Refinement Act of 1999 imposed a moratorium on the application of HCFA's "inherent reasonableness" authority. Thus, while the moratorium is in place, HCFA may not act on a determination that costs are excessive. The President's FY 2001 budget includes a proposal to reduce durable medical equipment payment updates from 2003 through 2005.

Report:

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

PREVENT MEDICARE LOSSES RESULTING FROM EARLY PAYMENTS FOR MEDICAL EQUIPMENT

Current Law:

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

Proposal:

We recommend that HCFA not pay for durable medical equipment, prosthetics, orthotics, and supply claims before the service period has been completed.

Legislative	Regulatory	Other Administrative
☐	☑	☐

Reason for Action:

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

Savings (in millions):

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

Status:

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

Report:

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

REDUCE PAYMENTS FOR PRESSURE SUPPORT SURFACES

Current Law:

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

Proposal:

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

Legislative	Regulatory	Other Administrative
☐	☐	☑

Reason for Action:

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

Savings (in millions):

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

Status:

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

Report:

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

REVISE MEDICARE GUIDELINES FOR CODING ORTHOTIC BODY JACKETS

Current Law:

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

Proposal:

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

Legislative	Regulatory	Other Administrative
☐	☐	☑

Reason for Action:

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

Savings (in millions):

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

Status:

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

Report:

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

REDUCE ALLOWED CHARGES FOR ORTHOTIC BODY JACKETS

Current Law:

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

Proposal:

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

Legislative	Regulatory	Other Administrative
☐	☐	✓

Reason for Action:

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

Savings (in millions):

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

Status:

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

Report:

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

IMPROVE BILLING PRACTICES FOR MEDICARE ORTHOTICS

Current Law:

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

Proposal:

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

Legislative	Regulatory	Other Administrative
☐	☐	✓

Reason for Action:

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

Savings (in millions):

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

Status:

Although HCFA concurred with our original recommendations, problems continue.

Report:

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

IMPROVE GUIDELINES FOR THERAPEUTIC FOOTWEAR

Current Law:

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

Proposal:

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

Legislative	Regulatory	Other Administrative
☐	☐	☑

Reason for Action:

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

Savings (in millions):

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

Status:

The HCFA concurred with our recommendations but indicated that implementation and related monitoring would be difficult given resource constraints.

Report:

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

ELIMINATE INAPPROPRIATE BILLING FOR BLOOD GLUCOSE TEST STRIPS

Current Law:

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

Proposal:

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

Legislative	Regulatory	Other Administrative
☐	☐	✓

Reason for Action:

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

Savings (in millions):

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

Status:

The HCFA concurred with our recommendations.

Report:

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

EXAMINE PAYMENT METHOD FOR PARENTERAL NUTRITION

Current Law:

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

Proposal:

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

Legislative	Regulatory	Other Administrative
✓		✓

Reason for Action:

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

Savings (in millions):

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

Status:

The Balanced Budget Act of 1997 enacted several provisions that would address our recommendation. Section 4316 authorizes HCFA to make "inherent reasonableness" adjustments up to 15 percent for all Part B services other than physician services. Also, section 4319 authorizes up to five competitive bidding demonstrations. The HCFA has convened a workgroup to focus on ways to reduce costs for parenteral nutrition. The Administration's FY 2001 budget proposes reducing the payment updates for parenteral and enteral items from 2003 through 2005.

Report:

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

REDUCE AND CONTROL ENTERAL NUTRITION EQUIPMENT COSTS

Current Law:

Enteral nutrition therapy, commonly called tube feeding, provides nourishment to patients who cannot swallow because of severe or permanent medical problems. This therapy, covered under Medicare Part B as a prosthetic benefit, is limited to patients unable to eat normally who require enteral therapy as their primary source of nutrition. The durable medical equipment regional carriers were created by Federal regulation in 1993 to establish medical policy and guidelines for the review of durable medical equipment claims.

Proposal:

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

Legislative	Regulatory	Other Administrative
✓		✓

Reason for Action:

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

Savings (in millions):

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

Status:

The HCFA agreed with our recommendation. Also, the Balanced Budget Act of 1997 contained several reforms related to reimbursement for beneficiaries in nursing homes, including a mandatory prospective payment system for Part A covered stays and consolidated billing for beneficiaries not in Part A covered stays. The Administration's FY 2001 budget proposes reducing the payment updates for parenteral and enteral items from 2003 through 2005.

Report:

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

REDUCE MEDICARE PART B PAYMENTS FOR ENTERAL NUTRITION AT HOME

Current Law:

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

Proposal:

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

Legislative	Regulatory	Other Administrative
☐	☐	✓

Reason for Action:

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

Savings (in millions):

	FY 1	FY 2	FY 3	FY 4	FY 5
Enteral payments for non-nursing-home residents	$15	$15	$15	$15	$15

Status:

The HCFA concurs that Medicare is paying too much for enteral nutrients and supports the recommendation to reduce payments for enteral therapy administered at home under Part B. Included in section 4552(a) of the Balanced Budget Act of 1997 is a provision to freeze Medicare payments for parenteral and enteral nutrition, equipment, and supplies for 1998 through 2002. The durable medical equipment regional carriers have proposed additional payment reductions through their use of their inherent reasonableness authority. The Administration's FY 2001 budget proposes reducing the payment updates for parenteral and enteral items from 2003 through 2005.

Report:

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

MINIMIZE PAYMENTS FOR PORTABLE IMAGING SERVICES

Current Law:

Nursing homes arrange for ancillary services (such as x-rays) for patients who require them. In some instances, firms known as portable imaging suppliers provide x-ray and electrocardiogram services in nursing homes. Before the prospective payment system for skilled nursing facilities was implemented, imaging services consisted of several components--technical, professional, transportation, and setup--depending on the type of service and where and by whom it was rendered.

Proposal:

The HCFA should seek legislation, as appropriate, to ensure that historically inflated payments are not built into the prospective payment system that will reimburse care provided under a Part A covered stay. Additionally, under Part B, payments for transportation should be limited to the national median (and prorated when multiple patients are seen), and payments for x-ray setup should be eliminated. The HCFA also should enforce the requirement that physicians justify the need for portable services.

Legislative	Regulatory	Other Administrative
✓	✓	✓

Reason for Action:

Medicare pays more than twice as much for imaging services when they are billed under arrangement than when payment is limited to the fee schedule. Also, the amounts Medicare carriers allow for transportation of portable x-ray equipment vary widely, and some are excessive. Additionally, there is no statutory requirement for HCFA to allow setup charges for portable x-rays, and these appear unjustified. Finally, our review of the medical records of nursing home residents receiving portable x-ray services showed that 31 percent of the records lacked a physician order for the portable service and that 53 percent lacked documentation that the patient was not ambulatory.

Savings (in millions):

	FY 1	FY 2	FY 3	FY 4	FY 5
Inflated Part A payments	$ 28.3	$ 30.0	$ 31.9	$ 33.9	$ 36.0
Transport and x-ray setup	37.5	38.6	39.9	41.4	43.0
Justification for portable service	63.7	68.6	73.9	79.6	85.8
Total	$129.5	$137.2	$145.7	$154.9	$164.8

Status:

The HCFA did not agree with our recommendations.

Report:

OEI-09-95-00090 (Final report, Nov. 1998)
OEI-09-95-00091 (Final report, Nov. 1998)

IMPROVE MEDICAL REVIEWS FOR HOME OXYGEN THERAPY

Current Law:

Medicare covers home oxygen therapy for beneficiaries diagnosed with significant hypoxemia (a deficiency in the amount of oxygen in the blood). A physician-signed certificate of medical necessity is required for payment. The Balanced Budget Act of 1997 mandated that the Secretary establish specific service standards for oxygen equipment as soon as practicable. Home oxygen therapy, for which over $2 billion was paid in 1997, accounts for the largest portion of Medicare payments for durable medical equipment.

Proposal:

The HCFA should target oxygen equipment claims for focused medical review and ensure that edits are in place at durable medical equipment regional carriers to identify incomplete certificates of medical necessity. Further, HCFA should work quickly to establish specific service standards for home oxygen equipment as mandated by the BBA.

Legislative	Regulatory	Other Administrative
☐	☑	☐

Reason for Action:

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

Savings (in millions):

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

Status:

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

Report:

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

STOP INAPPROPRIATE PAYMENTS FOR HYPERBARIC OXYGEN THERAPY

Current Law:

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

Proposal:

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

Legislative	Regulatory	Other Administrative
☐	☐	☑

Reason for Action:

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

Savings (in millions):

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

Status:

We are awaiting agency comments.

Report:

OEI-06-99-00090 (Draft report, July 2000)

MODIFY PAYMENTS TO MANAGED CARE ORGANIZATIONS

Current Law:

The Balanced Budget Act of 1997 established the Medicare+Choice (M+C) 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 M+C program to correct excess payments, reduce geographic variations in payment, and align managed care organization (MCO) payments to reflect beneficiaries' health status.

Proposal:

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

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

While some BBA provisions reduced payments to MCOs, the overall impact of BBA is that MCO payments for Calendar Year (CY) 2000 will be about 95.5 percent of the average amount paid in the Medicare fee-for-service (FFS) sector. Because the Balanced Budget Refinement Act of 1999 delayed full implementation of the health status risk adjustment factor, MCOs will receive about $1.8 billion more in CY 2000 Medicare payments than they would have received had the full risk adjustment been implemented. The BBA-required minimum 2 percent annual increase in MCO payments proved beneficial to MCOs overall. If MCOs had been paid under the pre-BBA payment methodology, that is, based on annual costs in the FFS sector, Medicare payments in 1998 and 1999 would have been lower than what was actually paid to MCOs. We believe that the effect is over $1.5 billion for CY 2000 MCO payments. In addition, several OIG reviews have shown that other factors should be considered when evaluating MCO payment rates. These include improper payments included in the 1996 FFS payments used to develop the 1997 base-period MCO payments; unaccounted-for investment income earned by MCOs on Medicare funds, resulting in about a 0.5 percent increase in MCOs' payments; and excessive administrative costs, equivalent to about 1.3 percent of CY 2000 Medicare MCO payments, included as part of MCOs' annual submissions to HCFA of revenue needs. We found that MCOs receive more than an adequate amount of funds to deliver the Medicare package of covered services; the base of payments on which MCOs are paid is incorrect, resulting in higher than necessary monthly capitation payments; and Medicare payments have been made to fund excessive administrative costs at MCOs.

Savings (in millions):

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

Status:

The HCFA agreed that M+C payments are adequate to fund the Medicare package of covered services. Agency officials stated that they will move toward full implementation of a risk adjustment methodology that will incorporate diagnosis data from physician services and hospital outpatient services.

Report:

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

ADJUST MANAGED CARE CAPITATION RATES FOR UNRECOVERED IMPROPER PAYMENTS

Current Law:

The Balanced Budget Act of 1997 revised the Medicare payment calculation methodology for managed care organizations effective January 1998. The new methodology is still linked to Medicare fee-for-service expenditures. The calculation uses as a base the 1997 county-specific capitation rates, which were based on 95 percent of the average cost of treating a beneficiary in the fee-for-service program. As such, 95 percent of any improper fee-for-service payments are included in the capitation rates.

Proposal:

The HCFA should pursue legislation that will allow modifications to the base managed care capitation rates, including an adjustment for the estimated unrecovered improper payments included in the rate calculations. The legislation should recognize the offsetting effect of any payments subsequently found to be proper or subsequently paid to the fee-for-service providers based on the provider appeals process.

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

Our audits of HCFA's financial statements estimated that the Medicare fee-for-service program improperly paid providers $23.2 billion, or 14 percent of total expenditures, in FY 1996 and $20.3 billion, or 11 percent of total expenditures, in FY 1997. Adjusting the managed care capitation payments to the lower limit of estimated improper payments would result in savings of at least 7 percent.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$2,000	$2,000	$2,000	$2,000	$2,000

Status:

The HCFA agreed that Medicare managed care payments have been overstated and should be reduced. However, HCFA did not agree that it would be appropriate to seek legislation as we recommended. Given the overall payment reduction to managed care organizations based on the Balanced Budget Act of 1997, HCFA questioned the merits of pursuing a second reduction based on a projection of audit findings that may change substantially from year to year. Subsequent to our report, the Congress modified the reductions of the BBA, and a legislative proposal was introduced to change the managed care payment system based on the BBA to a system based on bids submitted by the plans. The congressional change resulted in increasing managed care payments; the legislative proposal was not enacted.

Report:

A-14-97-00206 (Final report, Sept. 1998)

CORRECT OVERSTATED MANAGED CARE CAPITATION RATES

Current Law:

The Balanced Budget Act of 1997 revised the Medicare payment methodology for managed care organizations (MCOs) effective January 1998. The calculation uses as a base the 1997 county-specific rates. The BBA does not allow any adjustments to the 1997 base, other than a reduction for a small portion of the rates applicable to medical education expenses. The 1997 rates are updated each year by the national average per capita increase in Medicare expenditures minus a percentage specified in the law. The resulting capitation rate is the basis for Medicare payments to MCOs.

Proposal:

The HCFA should seek legislation to correct the overstated base-year rates or eliminate any future increases in managed care capitation rates.

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

Information provided by HCFA shows that the 1997 standardized county rates were based on actuarial estimates and, when compared with actual costs incurred, were overstated by 3.1 percent. Because the BBA established the 1997 county rates as the base year, all future managed care capitation rates will include this overstatement. To develop our savings estimate, we applied the 3.1 percent overstatement to Congressional Budget Office projections of future Medicare payments to MCOs.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$1,260	$1,480	$1,350	$1,630	$1,850

Status:

The HCFA's response to our draft report stated that the President's Medicare reform package included a proposal to change the methodology used to set payment rates for MCOs. Because this new methodology would not use the overstated base-year rates enacted under the BBA of 1997, HCFA believed the legislation we recommended, correcting the base-year rates, was unnecessary. The Medicare reform package is included in the Administration's FY 2001 budget.

Report:

A-05-99-00025 (Final report, Dec. 1999)

PAY MANAGED CARE ORGANIZATIONS ONLY REASONABLE ADMINISTRATIVE COSTS

Current Law:

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

Proposal:

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

Legislative	Regulatory	Other Administrative
✓		✓

Reason for Action:

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

Savings (in millions):

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

Status:

The HCFA did not agree with our recommendations.

Report:

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

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

Current Law:

Each risk-based managed care organization is required to submit an adjusted community rate proposal to HCFA 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. Unlike other areas of the Medicare program, HCFA does not require a reasonable percentage or ceiling on the administrative cost rate proposed.

Proposal:

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

Legislative	Regulatory	Other Administrative
✓		✓

Reason for Action:

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

Savings (in millions):

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

Status:

Although HCFA agreed that it should more thoroughly analyze rate proposals, it did not agree with our recommendation to institute a ceiling on the administrative costs included in an MCO rate proposal.

Report:

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

MONITOR INVESTMENT INCOME EARNED BY RISK-BASED MANAGED CARE ORGANIZATIONS

Current Law:

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

Proposal:

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

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

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

Savings (in millions):

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

Status:

The HCFA agreed that its policies should hold MCOs accountable for investment income earned on current Medicare funds and should ensure that investment income is used to benefit Medicare enrollees. However, HCFA noted that it does not intend to pursue legislative changes at this time.

Report:

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

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

Current Law:

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

Proposal:

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

Legislative	Regulatory	Other Administrative
☐	☐	✓

Reason for Action:

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

Savings (in millions):

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

Status:

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

Report:

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

PREVENT PAYMENTS TO MANAGED CARE PLANS FOR DECEASED BENEFICIARIES

Current Law:

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

Proposal:

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

Legislative	Regulatory	Other Administrative
☐	☐	✓

Reason for Action:

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

Savings (in millions):

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

Status:

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

Report:

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

ELIMINATE MEDICARE PAYMENTS FOR SERVICES AFTER DEATH

Current Law:

Medicare's Common Working File (CWF) host sites receive updated beneficiary information, including date of death, from HCFA's enrollment database on a daily basis. The data contained in the enrollment database is received daily from the Social Security Administration and the Railroad Retirement Board. In addition to receiving date of death from the enrollment database, the CWF received some date-of-death information directly from institutional claims submitted by intermediaries.

Proposal:

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

Legislative	Regulatory	Other Administrative
☐	☐	☑

Reason for Action:

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

Savings (in millions):

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

Status:

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

Report:

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

CHANGE THE WAY MEDICARE PAYS FOR CLINICAL LABORATORY TESTS

Current Law:

The amount the Medicare program pays for most clinical lab tests is based on fee schedules. These fee 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 Medicare fee schedule payments by lowering the cap to 74 percent of the median for payment amounts beginning in 1998. Also, there will be no inflation update between 1998 and 2002.

Proposal:

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

Legislative	Regulatory	Other Administrative
✓		✓

Reason for Action:

The Omnibus Budget Reconciliation Act of 1993, if fully implemented, should reduce the higher profit rates from Medicare billings. However, although prices on individual tests are being reduced by legislation, panels are still generally being billed as individual tests to Medicare. Medicare policies are not sufficient to control the billing of profile tests because there is no requirement that the tests ordered as a panel by the physician be billed only as a panel. The HCFA's guidelines do not address the problem of panels as a marketing mechanism of the laboratory industry or the problem of industry billing for the contents of the panels individually. In our opinion, these conditions have contributed to the significant increase in the use of laboratory services.

Savings (in millions):

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

**Copayment savings are also included in our proposal to roll reimbursement for laboratory services into the charge for physician office visits.*

Status:

The HCFA concurred with our first recommendation but not our second. A proposal to reduce payment updates from 2003 through 2005 is included in the President's FY 2001 budget, as is a proposal to reinstate laboratory cost sharing. In addition, the BBA required the Secretary to contract with the Institute of Medicine for a study of Part B laboratory test payments; HCFA may use the results to develop new payment methodologies.

Report:

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

PREVENT INAPPROPRIATE MEDICARE PAYMENTS FOR CLINICAL LABORATORY TESTS

Current Law:

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

Proposal:

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

Legislative	Regulatory	Other Administrative
☐	☐	✓

Reason for Action:

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

Savings (in millions):

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

Status:

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

Report:

A-01-96-00509 (Final report, Nov. 1997)
A-01-96-00527 (Final report, Nov. 1998)

ELIMINATE VULNERABILITIES TO MEDICARE OF INDEPENDENT DIAGNOSTIC TESTING FACILITIES

Current Law:

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

Proposal:

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

Legislative	Regulatory	Other Administrative
☐	☐	✓

Reason for Action:

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

Savings (in millions):*

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

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

Status:

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

Report:

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

REQUIRE PHYSICIAN EXAMINATION BEFORE ORDERING HOME HEALTH SERVICES

Current Law:

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

Proposal:

The HCFA should revise Medicare regulations to require the physician to examine the patient before ordering home health services. As discussed in the "Status" section, other OIG recommendations to correct abusive and wasteful practices are being addressed.

Legislative	Regulatory	Other Administrative
☐	✓	☐

Reason for Action:

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

Savings (in millions):

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

Status:

Although the Congress and the Administration included provisions to restructure home health benefits in the Balanced Budget Act of 1997, HCFA still needs to revise Medicare regulations to require that physicians examine Medicare patients before ordering home health services. Subsequent to implementation of the Balanced Budget Act, our four-State review found that unallowable services continued to be provided because of inadequate physician involvement. While agreeing in principle, HCFA said it would continue to examine both coverage rules and conditions of participation to develop the discipline necessary for ensuring proper certification.

Report:

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

ENSURE VALIDITY OF MEDICARE HOSPICE ENROLLMENTS

Current Law:

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

Proposal:

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

Legislative	Regulatory	Other Administrative
✓		✓

Reason for Action:

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

Savings (in millions):

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

Status:

The Balanced Budget Act of 1997 modified the hospice benefit but did not address the above recommendations. The HCFA has increased its scrutiny of hospice claims by subjecting an increased number of claims to medical review. No changes have been proposed to modify the payment methodology for dually eligible nursing facility residents. The President's FY 2001 budget proposes civil monetary penalties for false certification of the need for hospice care.

Report:

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

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

Current Law:

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

Proposal:

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

Legislative	Regulatory	Other Administrative
✓	✓	

Reason for Action:

To develop the prospective payment system rates, HCFA used cost reports for reporting periods beginning in FY 1995. However, HCFA 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.

Savings (in millions):

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

Status:

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

Report:

A-14-98-00350 (Final report, July 1998)
A-06-99-00058 (Final report, Dec. 1999)

ELIMINATE OVERPAYMENTS UNDER CONSOLIDATED BILLING BY SKILLED NURSING FACILITIES

Current Law:

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

Proposal:

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

Legislative	Regulatory	Other Administrative
☐	☐	✓

Reason for Action:

For over one-third of the claims reviewed, 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.

Savings (in millions):

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

Status:

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

Report:

A-01-99-00531 (Final report, Mar. 2000)

ADEQUATELY FUND MEDICAL REVIEWS OF THERAPY SERVICES

Current Law:

Medicare coverage guidelines state that therapy must be reasonable, necessary, specific, and an effective treatment for the patient's condition. The Balanced Budget Act of 1997 required HCFA to develop a prospective payment system for skilled nursing facilities effective for cost reporting periods beginning July 1, 1998.

Proposal:

The HCFA should adequately fund Medicare contractors to perform medical reviews of therapy. The inappropriate costs identified in our report should be considered if Federal prospective payment rates are modified or rebased.

Legislative	Regulatory	Other Administrative
☐	☐	✓

Reason for Action:

Based on our sample results, we estimated that for the 12-month period ending June 30, 1998, Medicare reimbursed skilled nursing facilities $955 million for improperly billed physical and occupational therapy. This therapy was not medically necessary and was provided by staff who did not have the appropriate skill for the patient's medical condition. We also estimated that Medicare reimbursed skilled nursing facilities almost $331 million for undocumented physical and occupational therapy. The results of our study, as well as implementation of the new prospective payment system, have implications for the need to ensure that therapy services are medically appropriate.

The cost of unnecessary and undocumented therapy was not identified prior to the implementation of the prospective payment system rates. As a result, the base-year cost data used to develop the rates was inflated by these unallowable costs.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$1,286	$1,286	$1,286	$1,286	$1,286

Status:

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

Report:

OEI-09-97-00122 (Final report, Aug. 1999)

STRENGTHEN CONTROLS OVER PARTIAL HOSPITALIZATION PROGRAMS AT COMMUNITY MENTAL HEALTH CENTERS

Current Law:

The Omnibus Budget Reconciliation Act of 1990 authorized Medicare coverage and payment for partial hospitalization program services provided by community mental health centers. The services must be reasonable and necessary for the diagnosis and active treatment of an individual's mental condition in order to prevent a relapse or hospitalization.

Proposal:

Among other things, HCFA should either develop conditions of participation for community mental health centers or conduct onsite surveys during the provider enrollment process, instruct fiscal intermediaries to perform a detailed medical review of the first claim submitted for each new beneficiary receiving partial hospitalization services from a center, take strong action against those centers that did not meet HCFA's qualification requirements, institute overpayment recovery actions, develop a plan to review all claims for centers across the Nation, and evaluate the propriety of allowing the centers to provide the partial hospitalization benefit.

Legislative	Regulatory	Other Administrative
✓	✓	✓

Reason for Action:

Significant problems were found during joint HCFA-OIG reviews of 14 centers in Florida and Pennsylvania, a broader review of centers in five States with high Medicare expenditures for partial hospitalization services, and a 9-State center enrollment initiative by HCFA. Center certification requirements were not always met, beneficiaries were ineligible for the services, services were not reasonable and necessary and/or were recreational and diversionary in nature rather than therapeutic, and provider cost reports contained unallowable and nonreimbursable costs.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$260	TBD	TBD	TBD	TBD

Status:

The HCFA concurred with our recommendations and developed a 10-point initiative to address both immediate and long-term actions. Among other things, HCFA's initiative includes the termination of egregious centers, intensified medical reviews, overpayment collections, and proposal of various legislative actions. The President's FY 2001 budget proposes to establish more stringent standards for community mental health centers.

Report:

A-04-98-02145 (Final report, Oct. 1998)
A-04-98-02146 (Final report, Oct. 1998)

REVISE MEDICARE PRESCRIPTION DRUG PAYMENT METHODS

Current Law:

Medicare Part B covers prescription drugs incident to a physician's services for drugs that cannot be self-administered, for certain medical disorders, such as end stage renal disease and cancer, and when necessary for the effective use of durable medical equipment. Reimbursement is based on the lower of estimated actual charges or a national average wholesale price (AWP) less 5 percent. Payment for drugs under the Medicaid program varies among the States but generally includes use of a discounted acquisition cost, as well as a federally mandated manufacturer's rebate program.

Proposal:

The HCFA should reexamine its Medicare drug reimbursement methodologies with a goal of reducing payments as appropriate.

Legislative	Regulatory	Other Administrative
✓	✓	✓

Reason for Action:

Findings of several OIG reports provide evidence that Medicare and its beneficiaries are making excessive payments for prescription drugs. The published average wholesale prices currently used by Medicare-contracted carriers to determine reimbursement bear little or no resemblance to actual wholesale prices available to the physician and supplier communities that bill for these drugs. We believe that the 5 percent reduction in AWP mandated by the Balanced Budget Act is not enough and that further options to reduce reimbursement should be considered. We also found that Medicare and its beneficiaries could have saved $1 billion in 1998 if the allowed amounts for 34 drugs had been equal to prices obtained by the Department of Veterans Affairs.

Savings (in millions):*

FY 1	FY 2	FY 3	FY 4	FY 5
$1,000	$1,000	$1,000	$1,000	$1,000

**Includes beneficiary copayment amounts.*

Status:

The HCFA concurred with our recommendation. The President's FY 2001 budget proposes to further reduce outpatient drugs by reimbursing these items at 83 percent of AWP.

Report:

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

ESTABLISH FEE SCHEDULE FOR MEDICARE AMBULANCE PAYMENTS

Current Law:

Medicare pays for medically necessary ambulance services when the use of other methods of transportation are contraindicated by the beneficiary's condition. Two levels of service, advanced and basic life support, are covered by Medicare. Reimbursement is based on the type of vehicle and personnel used (advanced or basic life support) and the service status (emergency or nonemergency).

Proposal:

The HCFA should establish new guidelines for ambulance payments:

- Work with the ambulance industry to develop clearer guidelines on what is and is not included in the base rate and what mileage is intended to cover.
- Eliminate separate payments for oxygen, supplies, injectables, and other services, such as electrocardiograms. These items should be included in the base rate.
- Limit the number of procedure codes available to ambulance suppliers for billing.

Legislative	Regulatory	Other Administrative
☐	✓	☐

Reason for Action:

Medicare payments for ambulance services appear to lack common sense and are vulnerable to fraud and abuse. For example, in 26 States, Medicare pays more for routine, nonemergency basic life support than it does for advanced life support emergency transportation.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$242	$242	$242	$242	$242

Status:

The Balanced Budget Act of 1997 mandated the establishment of a fee schedule for Medicare ambulance transportation. Although the law calls for negotiated rulemaking, there is a provision that would allow Medicare to incorporate some savings into the fee schedule. We believe that additional savings beyond those contemplated in legislation are possible. The recommendations will be addressed in the forthcoming Federal Register which implements the Medicare ambulance fee schedule, anticipated to take effect January 1, 2001.

Report:

OEI-05-95-00300 (Final report, Nov. 1997)

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

Current Law:

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

Proposal:

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

Legislative	Regulatory	Other Administrative
☐	✓	☐

Reason for Action:

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

Savings (in millions):

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

Status:

The Balanced Budget Act of 1997 required that HCFA link payments to services provided and that the definitions of basic life support and advanced life support ambulance services be subject to negotiated rulemaking. The Negotiated Rulemaking Committee Statement on the Medicare Ambulance Services Fee Schedule was signed on February 14, 2000. The HCFA published the proposed rule titled "Fee Schedule for Payment of Ambulance Services and Revisions to the Physician Certification Requirements for Coverage of Nonemergency Ambulance Services" in the Federal Register on September 11, 2000.

Report:

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

ENSURE THE MEDICAL NECESSITY OF AMBULANCE CLAIMS

Current Law:

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

Proposal:

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

Legislative	Regulatory	Other Administrative
☐	☐	✓

Reason for Action:

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

Savings (in millions):*

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

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

Status:

The HCFA has completed negotiated rulemaking on development of the Medicare ambulance fee schedule and is in the process of proposing regulations. The fee schedule is planned to go into effect in January 2001. The HCFA contracted for a study related to nonemergency ambulance transportation and is currently reviewing the results to determine the appropriate actions to take in light of the new fee schedule and the codes associated with the schedule. As the new codes are established, HCFA intends to explore appropriate edits.

Report:

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

STOP INAPPROPRIATE PAYMENTS FOR CHIROPRACTIC MAINTENANCE TREATMENTS

Current Law:

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

Proposal:

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

Legislative	Regulatory	Other Administrative
☐	☐	☑

Reason for Action:

We found that Medicare, Medicaid, and private insurers rely, in varying degrees, on utilization caps, x-rays, physician referrals, copayments, and prepayment and postpayment reviews to control utilization of chiropractic benefits. Utilization copayments are the most widely used, but these and other controls did not detect or prevent unauthorized Medicare maintenance treatments. We concluded that in 1996, 759,400 Medicare beneficiaries received 2,888,900 probable chiropractic maintenance treatments at a cost to the Medicare program of $68,882,100.

Savings (in millions):

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

Status:

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

Report:

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

ESTABLISH UTILIZATION PARAMETERS FOR CHIROPRACTIC TREATMENTS

Current Law:

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

Proposal:

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

Legislative	Regulatory	Other Administrative
☐	☐	☑

Reason for Action:

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

Savings (in millions):

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

Status:

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

Report:

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

PROVIDE EXPLICIT GUIDELINES ON ALLOWABILITY OF INSTITUTIONAL GENERAL AND ADMINISTRATIVE AND FRINGE BENEFIT COSTS

Current Law:

The HCFA guidelines--Provider Reimbursement Manual, section 2100--establish the general principle that payments to a provider must be for covered services under Medicare. Sections 2102.1, 2102.2, and 2103 of the manual expand this principle by explaining factors that affect the allowability of costs, such as the reasonableness of costs, their relationship to patient care, and the prudent buyer concept.

Proposal:

The HCFA should revise the Provider Reimbursement Manual to provide explicit guidelines on the allowability of certain general and administrative and fringe benefit costs.

Legislative	Regulatory	Other Administrative
☐	☐	✓

Reason for Action:

We reviewed general and administrative and fringe benefit costs at 19 selected providers and 2 home offices nationwide in response to a request from the Subcommittee on Oversight and Investigations, House Committee on Energy and Commerce. For 16 of the 19 providers reviewed, Medicare participated in approximately $50.7 million of costs that were unallowable, unreasonable, or not allocable to the Medicare program. Although Medicare's share amounted to approximately $2.1 million, the bulk of the costs were passed on to other health care consumers. Also, $3.5 million of costs are "costs for concern" because of their tenuous relationship to patient care. We believe that many of the unallowable costs resulted from the providers' lack of adequate internal controls. However, other unallowable costs, as well as the "costs for concern," appear to have resulted from different interpretations of the guidelines in HCFA's Provider Reimbursement Manual, which is the principal guideline used by providers to charge costs to the Medicare program.

Savings (in millions):

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

Status:

The HCFA has published changes to the Provider Reimbursement Manual to clarify the allowability of several of the cost categories identified in our report. In addition, the Balanced Budget Act of 1997 prohibited payments for such items as entertainment, gifts, and donations. The HCFA should clarify the remaining cost categories noted in our report.

Report:

A-03-92-00017 (Final report, Aug. 1994)

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

Current Law:

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

Proposal:

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

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

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

Savings (in millions):

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

Status:

The President's FY 2001 budget does not include such a proposal.

Report:

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

RAISE THE MEDICARE ENTITLEMENT AGE TO 67

Current Law:

The Social Security Act and related laws established a number of Federal programs, including Social Security Retirement Insurance benefits and the Medicare program. Historically, Social Security and Medicare have been closely linked. Both established age 65 as their entitlement age for the nondisabled population. The Social Security Amendments of 1983 increased the age of entitlement for Social Security unreduced benefits from age 65 to age 67 over the transition period 2003 to 2027. This was done as one of several methods to strengthen the solvency of the Social Security Trust Fund. However, the age of entitlement for Medicare has remained unchanged.

Proposal:

The HCFA should gradually increase the Medicare entitlement age to 67, following the same schedule for the increase in the age of entitlement to unreduced Social Security benefits.

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

If the Medicare entitlement age were gradually raised to age 67 following the same schedule as the Social Security program, the Medicare Hospital Insurance Trust Fund would save three quarters of a trillion dollars over a 30-year period beginning in 2003. The Medicare Supplementary Medical Insurance program would also save significant amounts, and since the impact of raising the entitlement age on future Medicare beneficiaries is not known, potential negative consequences could be reduced by providing substantial advance notice of the change. The proposal could help alleviate the Federal deficit and deal with the projected solvency of the trust fund.

Savings (in millions):*

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

**Savings, which would be substantial, would first be realized in 2003, increasing each year until 2027 when the entitlement age reaches 67.*

Status:

The President's FY 2001 budget does not include a proposal to raise the entitlement age.

Report:

OEI-07-91-01600 (Final report, Nov. 1992)

IMPROVE MEDICARE SECONDARY PAYER SAFEGUARDS

Current Law:

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

Proposal:

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

Legislative	Regulatory	Other Administrative
✓		✓

Reason for Action:

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

Savings (in millions):*

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

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

Status:

The HCFA is pursuing the recommended administrative actions through improved processes to identify and recover overpayments related to MSP. In this regard, the coordination-of-benefits contract has been awarded, and all MSP development will be coordinated under this contract. In addition, HCFA supports legislation that would require all group health plans to report information to Medicare, and the President's FY 2001 budget proposes a requirement that private insurance companies provide Medicare secondary payer information. The HCFA is also negotiating data-sharing agreements with several State workers' compensation boards.

Report:

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

EXPAND MEDICARE SECONDARY PAYER PROVISIONS FOR END STAGE RENAL DISEASE BENEFITS

Current Law:

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

Proposal:

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

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

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

Savings (in millions):

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

Status:

The HCFA was concerned that an indefinite secondary payer provision might encourage insurers to drop uneconomical services, namely facility dialysis and transplantation. Although the Balanced Budget Act of 1997 extended MSP provisions for individuals with ESRD to 30 months, we continue to advocate that when Medicare eligibility is due solely to ESRD, the group health plan should remain primary until the beneficiary becomes entitled to Medicare based on age or disability and is not currently employed. At that point, Medicare would become the primary payer.

Report:

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

MODIFY THE FORMULA FOR THE MEDICAID PROGRAM

Current Law:

The Federal Medical Assistance Percentage prescribed in the Social Security Act determines the Federal share of costs for Medicaid and various other programs.

Proposal:

The HCFA should consult with the Congress on modifications to the Federal Medical Assistance Percentage formula which would result in distributions of Federal funds that more closely reflect per-capita-income relationships.

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

The Federal Medical Assistance Percentage formula does not fully reflect the congressional objective of distributing Federal funds according to a State's ability to share in program costs, as measured by State per capita income. Due to two provisions, higher income States receive significant additional Federal funds beyond amounts the formula would provide if it were based solely on per-capita-income relationships. Changes to these provisions, namely (1) eliminating the program growth incentive of the formula and (2) lowering the current minimum floor to 45 percent (from 50 percent), would result in distributions of Federal funds that more closely reflect per-capita-income relationships. If the formula were changed, higher income States (such as New York and California) would receive a reduced Federal share in program expenditures, while lower income States (such as Mississippi and Arkansas) would receive a greater Federal share. If a cost-of-living factor were added to the formula, it would help ensure that any reductions in Federal sharing would be more equitable.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$4,100	$4,100	$4,100	$4,100	$4,100

Status:

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

Report:

A-06-89-00041 (Final report, Aug. 1991)

LIMIT MEDICAID REIMBURSEMENT FOR HIGHER PRICED GENERIC DRUGS TO THE AMOUNT REIMBURSED FOR LOWER PRICED BRAND NAME DRUGS

Current Law:

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

Proposal:

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

Legislative	Regulatory	Other Administrative
☐	✓	✓

Reason for Action:

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

Savings (in millions):

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

Status:

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

Report:

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

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

Current Law:

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

Proposal:

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

Legislative	Regulatory	Other Administrative
✓		✓

Reason for Action:

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

Savings (in millions):*

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

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

Status:

The HCFA disagreed with the recommendation to submit a legislative proposal to the Congress, believing that such legislation was not feasible at the time. However, HCFA stated that changing AMP to AWP would reduce the administrative burden involved in the AMP calculations and planned a comprehensive study of AWP.

Report:

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

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

Current Law:

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

Proposal:

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

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

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

Savings (in millions):

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

Status:

We are continuing to monitor the Medicaid drug rebate program; audits will continue to focus on enhancing the collection of rebates and providing potential savings to the rebate program.

Report:

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

INSTALL EDITS TO PRECLUDE IMPROPER MEDICAID REIMBURSEMENT FOR CLINICAL LABORATORY SERVICES

Current Law:

Clinical diagnostic laboratory tests performed in a physician's office, by an independent laboratory, or by a hospital laboratory for its outpatients are reimbursed on the basis of fee schedules. Medicaid reimbursement for these tests may not exceed the amount that Medicare recognizes, and each Medicare carrier in a State is to provide its fee schedule to the State agency. For purposes of the fee schedule, clinical diagnostic laboratory services include laboratory tests listed in codes 80002 - 89399 of the Current Procedural Terminology Manual. Effective for services rendered on or after July 1, 1984, Federal matching funds are not available for any amount over the amount recognized by Medicare for such tests.

Proposal:

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

Legislative	Regulatory	Other Administrative
☐	☐	☑

Reason for Action:

Overall, our reviews disclose that State agencies are reimbursing providers for laboratory services that exceed the Medicare limits or are duplicated for payment purposes. These overpayments are occurring because the State agencies do not have adequate computer edits in place to prevent the payment of unbundled or duplicated claims for chemistry, hematology, or urinalysis tests.

Savings (in millions):

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

Status:

The HCFA wrote to all State Medicaid directors on January 15, 1997, alerting them to the OIG review, encouraging them to use Medicare's bundling policies, and urging them to install appropriate payment edits in their claim processing systems. The OIG is currently performing several followup reviews in this area. The status will be updated as these reviews progress.

Report:

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

CONTROL MEDICAID PAYMENTS TO INSTITUTIONS FOR MENTALLY RETARDED PEOPLE

Current Law:

Federal Medicaid rules for reimbursing States for intermediate care facilities/mentally retarded are not tailored to the operations of these institutions. At the time of our study, States were required to pay "reasonable costs" incurred by "efficiently and economically operated facilities." Section 4711 of the Balanced Budget Act of 1997 repealed these requirements. Current Federal Medicaid rules allow each State considerable discretion in setting payment methodology for these types of facilities.

Proposal:

The HCFA should reduce excessive spending of Medicaid funds for intermediate care facilities/mentally retarded by one or more of the following:

- Take administrative action to control reimbursement by encouraging States to adopt controls.
- Seek legislation to control reimbursement, such as through mandatory cost controls, Federal per capita limits, flat per capita payments, case-mix reimbursements, or a national ceiling for reimbursements.
- Seek comprehensive legislation to restructure Medicaid reimbursement for both intermediate care facilities/mentally retarded and home and community-based waiver service for developmentally disabled people via global budgeting, block grants, or financial incentive programs.

Legislative	Regulatory	Other Administrative
✓		✓

Reason for Action:

Medicaid reimbursement rates for large intermediate care facilities/mentally retarded are more than five times greater in some States than in others. The average Medicaid reimbursement in 1991 for large facilities ranged among States from $27,000 to $158,000 per resident. This variation was unrelated to the patients' severity of illness, quality of service, facility characteristics, or resident demographics. A lack of effective controls results in excessive spending.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$683	$683	$683	$683	$683

Status:

The HCFA sent copies of our report to State Medicaid Directors but did not concur with our recommendation. The HCFA believes Medicaid statutory provisions allow States to establish their own payment systems. This flexibility allows for the variations found among States in their payment rates and the methods and standards used in determining these rates. Section 4711 of the Balanced Budget Act of 1997 required the Secretary to conduct a study on the effect of the States' rate-setting methods on access to, and quality of, services provided to beneficiaries.

Report:

OEI-04-91-01010 (Final report, June 1993)

PUBLIC HEALTH SERVICE AGENCIES

Public Health Service Agencies

Overview

The activities conducted and supported by the Public Health Service (PHS) operating divisions represent this country's primary defense against acute and chronic diseases and disabilities. These programs provide the foundation for the Nation's efforts in promoting and enhancing the continued good health of the American people.

These independent operating divisions include the National Institutes of Health (NIH), to advance our knowledge through research; the Food and Drug Administration (FDA), to ensure the safety and efficacy of marketed drugs, biological products, and medical devices and the safety of food and cosmetics; the Centers for Disease Control and Prevention (CDC), to combat preventable diseases and protect the public health; the Health Resources and Services Administration (HRSA), to support the development, distribution, and management of health care personnel, other health resources, and services; the Indian Health Service (IHS), to improve the health status of Native Americans; the Agency for Toxic Substances and Disease Registry (ATSDR), to address issues related to Superfund toxic waste sites; the Agency for Healthcare Research and Quality (AHRQ), to enhance the quality and appropriateness of health care services and access to services through scientific research and the promotion of improvements in clinical practice and in the organization, financing, and delivery of services; and the Substance Abuse and Mental Health Services Administration (SAMHSA), to assist States in refining and expanding treatment and prevention services.

Significant OIG Activities

The Office of Inspector General (OIG) concentrates on such issues as biomedical research, substance abuse, acquired immune deficiency syndrome, and food and drug safety. Significant unimplemented monetary recommendations identified by the OIG relate to instituting and collecting user fees for FDA activities and changing Office of Management and Budget Circular A-21 to effect more productive use of Federal research dollars at the Nation's colleges and universities.

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

Current Law:

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

Proposal:

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

Legislative	Regulatory	Other Administrative
✓	✓	✓

Reason for Action:

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

Savings (in millions):

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

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

Status:

The IHS fully concurred with our recommendations. This proposal is on the Department's list of legislative initiatives for 2002. The IHS notes that by applying a 5 percent inflation factor, the savings projection for 2002 would be almost $11 million.

Report:

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

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

Current Law:

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

Proposal:

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

Legislative	Regulatory	Other Administrative
☐	☐	✓

Reason for Action:

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

Savings (in millions):

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

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

Status:

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

Report:

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

ADMINISTRATION FOR CHILDREN AND FAMILIES

Administration for Children and Families

Overview

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

To reduce dependency on welfare programs, the Personal Responsibility and Work Opportunity Act of 1996 eliminated the Aid to Families with Dependent Children, Emergency Assistance, and Job Opportunities and Basic Skills Training programs as of FY 1997 and created the Temporary Assistance for Needy Families (TANF) block grant. The ACF oversees TANF, as well as the Child Support Enforcement program, which provides grants to States to enforce obligations of absent parents and to establish and enforce child support orders, and the Head Start program, which provides comprehensive health, educational, nutritional, social, and other services primarily to economically disadvantaged preschool children and their families. Also, the Foster Care and Adoption Assistance program provides grants to States to assist with the cost of foster care and special needs adoptions, as well as maintenance, administrative, and staff training costs. Other programs include Community Services and the Child Welfare program.

Significant OIG Activities

The Office of Inspector General (OIG) reviews the cost effectiveness of ACF social services and assistance programs, including determining whether authorized services are provided to recipients at the lowest costs. These reviews have identified opportunities to improve the delivery of program services, as well as recover unallowable costs.

RECOVER UNALLOWABLE FOSTER CARE MAINTENANCE PAYMENTS AND ADMINISTRATIVE COSTS

Current Law:

The Adoption Assistance and Child Welfare Act of 1980, Public Law 96-272, established the Title IV-E program, Federal Payments for Foster Care and Adoption Assistance. Title IV-E provides for the Federal Government to share in the payment of maintenance costs and related administrative costs associated with the care of foster children.

Proposal:

The States reviewed should refund unallowable costs to the Federal Government and make appropriate adjustments to their quarterly expenditure reports to accurately reflect maintenance payments made.

Legislative	Regulatory	Other Administrative
☐	☐	✓

Reason for Action:

The States reviewed (1) incorrectly claimed unallowable or ineligible Title IV-E maintenance payments; (2) used an incorrect Federal financial participation rate applicable to administrative costs; (3) incurred errors in the manual processing of claims for emergency foster care; (4) used inaccurate payment information to claim reimbursement for payments made by the State health care agencies; and/or (5) claimed contingency fee contract costs that are not permitted.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$77.9				

Status:

The ACF verbally concurred with our findings and recommendations and is in the process of resolving each finding with the individual States.

Report:

A-01-98-02505 (Final report, Feb. 2000)
A-02-97-02002 (Final report, Feb. 2000)
A-04-98-00126 (Final report, Aug. 2000)
A-05-99-00004 (Final report, Feb. 2000)

OBTAIN GOVERNMENT REIMBURSEMENT FOR HEAD START GRANTEES' UNALLOWABLE CHARGES

Current Law:

Federal regulation requires that nonfederal matching and cost sharing contributions be verifiable and allowable under the applicable cost principles and that the granting agency preapprove certain changes in the budget and in the grant award proposal. In addition, compensatory time payments are allowed if they follow the grantee's own policy for such payments.

Proposal:

The Federal Government should be reimbursed for ineligible expenditures.

Legislative	Regulatory	Other Administrative
☐	☐	✓

Reason for Action:

Grantees claimed unallowable costs, including (1) noncompliance with budget provisions and deviations from grant award proposals ($1,308,952), (2) irregularities in financial accounting ($345,461), (3) noncompliance with preapproval requirements for construction ($351,895), (4) unrecorded liabilities ($216,746), and (5) unsupported nonfederal matching funds ($1,351,353).

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$3.5				

Status:

Some grantees did not agree with our findings and recommendations. The ACF is using our findings and recommendations as part of its monitoring activity.

Report:

A-06-96-00062 (Final report, Aug. 1996)
A-07-98-01037 (Final report, Aug. 1998)
A-07-99-01039 (Final report, Aug. 1999)
A-08-96-01024 (Final report, Feb. 1997)
A-10-96-00007 (Final report, Mar. 1997)
A-12-96-00017 (Final report, July 1996)

RECOVER COSTS CLAIMED UNDER THE EMERGENCY ASSISTANCE PROGRAM

Current Law:

Title IV-A, Section 406(e) of the Social Security Act established the Emergency Assistance program to assist eligible children and families though emergency or crisis situations by providing temporary financial assistance and supportive services. On September 12, 1995, ACF notified State agencies that Federal financial participation was not available under the Emergency Assistance program for costs associated with providing benefits or services to children in the juvenile justice system who had been removed from their homes as a result of their alleged, charged, or adjudicated delinquent behavior.

Proposal:

Selected States should reduce Federal accounts for improper costs claimed, and ACF should recover the overpayments.

Legislative	Regulatory	Other Administrative
☐	☐	✓

Reason for Action:

The States that we reviewed claimed costs that were unallowable or did not meet requirements under the Emergency Assistance program.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$261.1				

Status:

The ACF concurred with our findings and recommendations. The agency notes that under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, States may use TANF funds to cover the costs of juvenile justice services.

Report:

A-02-99-02007 (Final report, Sept. 1999)
A-02-98-02002 (Final report, Feb. 2000)
A-03-98-00590 (Final report, Sept. 1998)
A-03-98-00592 (Final report, Apr. 2000)
A-03-99-00594 (Final report, Aug. 2000)
A-04-97-00109 (Final report, July 1998)
A-04-98-00122 (Final report, Sept. 1999)
A-04-98-00125 (Final report, Oct. 1998)
A-05-99-00063 (Final report, July 2000)
A-07-98-01035 (Final report, Apr. 1999)
A-07-99-01041 (Final report, July 2000)

RECOVER UNALLOWABLE OFFICE OF COMMUNITY SERVICES DISCRETIONARY GRANT CHARGES

Current Law:

The Office of Community Services (OCS) was established in the Department of Health and Human Services by the Community Services Block Grant Act of 1981. The OCS has discretionary authority to make funds available via grants to support program activities of national or regional significance to alleviate the causes of poverty in distressed communities. The objectives of the program include promoting full-time permanent jobs for poverty-level individuals and providing income and/or ownership opportunities for low-income individuals.

Proposal:

The grantees should refund unallowable costs to the Federal Government and coordinate with ACF on the resolution of the costs set aside.

Legislative	Regulatory	Other Administrative
☐	☐	✓

Reason for Action:

The grantees that we reviewed claimed costs that were unallowable or unsupported.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$0.1				

Status:

The grantees concurred with our findings and recommendations. The ACF is using our findings and recommendations as part of its monitoring activity.

Report:

A-09-98-00065 (Final report, Jan. 1999)
A-10-98-00008 (Final report, Dec. 1998)

GENERAL DEPARTMENTAL MANAGEMENT

General Departmental Management

Overview

The Office of Inspector General's (OIG) departmental management and Governmentwide oversight role includes reviews of payroll activities, accounting transactions, implementation of the Federal Managers' Financial Integrity Act and the Prompt Pay Act, financial management audits under the Chief Financial Officers Act, grant and contract issues, the Department's Working Capital Fund, conflict resolution, State and local government cost allocation plans and separate indirect cost plans of State agencies and local governments, and adherence to employee standards of conduct. The OIG also participates in interagency efforts through the President's Council on Integrity and Efficiency to prevent losses to and abuses of Federal programs.

A related major responsibility flows from Office of Management and Budget (OMB) Circular A-133, which designates HHS as the cognizant audit agency for most States and major research organizations. The OIG oversees the work of nonfederal auditors of Federal money at some 6,700 entities, such as community health centers and Head Start grantees, as well as at State and local governments, colleges and universities, and other nonprofit organizations. In addition, OIG is responsible for auditing the Department's financial statements beginning with the FY 1996 statements.

Significant OIG Activities

The OIG's work in departmental management and Governmentwide oversight focuses principally on financial statement audits, financial management and managers' accountability for resources entrusted, standards of conduct and ethics, and Governmentwide audit oversight, including recommending necessary revisions to OMB guidance. The OIG also reviews the adequacy of States' systems to control the growth of administrative/indirect costs claimed for Federal financial participation.

IMPROVE FUNDING SYSTEM FOR WELFARE ADMINISTRATIVE COSTS

Current Law:

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

Proposal:

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

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

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

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

Savings (in millions):

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

Status:

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

Report:

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

INTERNET ADDRESS

The ***2001 Red Book*** and other OIG materials, including final reports issued and OIG program exclusions, may be accessed on the Internet at the following address:

http://www.os.dhhs.gov/oig