PRESIDENT CLINTON UNVEILS LEGISLATIVE AND ADMINISTRATIVE PROPOSALS TO FIGHT MEDICARE FRAUD, WASTE, AND ABUSE
December 7, 1998

Today, President Clinton announced additional steps to fight fraud, waste, and abuse in the Medicare program, building on the Administration's longstanding efforts in this area. The President unveiled a legislative package that will save Medicare over $2 billion. He also announced new administrative measures to crack down on fraud, including efforts to make Medicare contractors more effective and accountable. Today in an event with the Administrator of the Health Care Financing Administration (HCFA), the HHS Inspector General, Senator Tom Harkin, and the Older Women's League, the President:

ANNOUNCED NEW LEGISLATIVE PACKAGE THAT WILL SAVE MEDICARE OVER $2 BILLION BY COMBATING FRAUD, WASTE, AND ABUSE. President Clinton will send Congress a comprehensive legislative package to fight fraud, waste, and abuse in the Medicare program as part of his FY2000 budget proposal. These proposals, which are consistent with recommendations made by the HHS Office of the Inspector General (OIG) in recent reports and some of which have been recommended to Congress before, will give HCFA more tools to root out fraud, abuse, and waste in Medicare. The proposals include:

- **Eliminating Excessive Medicare Reimbursement for Drugs.** A recent report by the OIG confirmed that Medicare currently pays hundreds of millions of dollars more for 22 of the most common and costly drugs than it would if it used market prices. For more than one-third of these drugs, Medicare paid more than double the average wholesale price, and in one case paid ten times the amount. This proposal would base Medicare payments on the actual acquisition cost of these drugs to the provider, eliminating current mark-ups and thereby substantially reducing Medicare costs.

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Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

Medicare Reimbursement for Hospital Beds in the Home

Prices

JUNE GIBBS BROWN
Inspector General

NOVEMBER 1998
OEI-07-96-00221

EXECUTIVE SUMMARY

PURPOSE

To determine the reasonableness of Medicare's reimbursement for rental of hospital beds in the home when compared to other Federal, State, private insurance companies, and managed care organizations.

BACKGROUND

Medicare authorizes beneficiaries to obtain hospital beds for use in their home. This is done on the basis of a rental schedule with an option to purchase the bed. Suppliers receive monthly reimbursement from the Medicare Durable Medical Equipment Regional Carriers based upon a fee schedule. This schedule is limited by the Health Care Financing Administration's (HCFA) established national payment ceilings, and is adjusted annually for inflation based upon the Consumer Price Index. The rental fee schedule caps the rental payments at 120 percent of the allowable charge for purchase. In calendar year (CY) 1996, Medicare allowed charges of over $272 million for the four categories of hospital beds included in this study. Semi-electric beds (code E0260) comprised 86 percent of this total while total electric beds accounted for less than one-half of one percent

We surveyed sampled entities from Medicare risk managed care organizations, Medicaid State Agencies, the top 50 health insurance companies as ranked by policies in force, and a listing of companies providing national and local coverage in the Federal Employees Health Benefits program. Overall, we achieved an 82 percent response rate.

This is one of two reports examining Medicare's policies and reimbursement for hospital bed equipment. A companion report ***"Medicare Reimbursement for Hospital Beds in the Home: Payment Methodology" OEI-07-96-00222*** compares Medicare's rental reimbursement payment methodologies to those of other medical insurance payers.

FINDING

Medicare Rates for Rental of Hospital Beds for Home Use Are Substantially Higher than Rates Paid by Most Other Payers

Comparison of Average Monthly Rental Payments for Semi-Electric Beds

Ninety-seven percent of our respondents pay for rental of hospital beds (72 of 74 respondents). We analyzed the rates for each hospital bed to identify the entities that paid uniform rates for rental and those that paid variable rates which depend on locale and market competition.

Of the 51 entities furnishing information on both the rental rates and the frequency of these payments for the four categories of hospital beds included in this inspection, 37 (72.6 percent) use a uniform monthly rate schedule, and 14 (27.4 percent) pay variable rates.

We found that on average, other payers' uniform monthly rental rates were more than 14 percent lower than the corresponding Medicare monthly rate for semi-electric hospital beds. For entities using a variable rate schedule, their highest rate ranged from 22 percent above to almost 23 percent below the corresponding Medicare average rate for this bed. We found similar results for manual, manual-adjustable, and total-electric hospital beds.

Comparison of Actual Monthly Rental Rates for Semi-Electric Beds

Since Medicare, unlike other entities, pays an enhanced rate for the first 3 months of rental, we also compared their actual rate for months 1 - 3 and months 4 - 15 to the rates of other entities. We found Medicare's rates for months 1 - 3 were from 18 percent to 38 percent higher, and for months 4 - 15 were from 9 percent lower to 18 percent higher.

Maximum Potential Rental Payments

We compared Medicare's rental payments for a semi-electric hospital bed during the maximum potential rental period of 15 months to other payers' maximum rental payments. We found entities paying a uniform rate were on average over 30 percent lower than Medicare's maximum payments. Also, entities who predominately reimburse from their highest variable rate schedule were on average 30 percent lower. Those payers primarily paying from their lowest rate schedule were on average 43 percent lower. Similar results were obtained for manual, manual-adjustable and total-electric hospital beds.

RECOMMENDATION

HCFA Should Take Immediate Steps to Reduce Medicare Payments for In-Home Hospital Beds

Medicare's monthly rates for the four types of hospital beds studied, when considered with total rental payments during the 15 month extended rental period, exceed the rates of other payers by more than 14 percent. The Balanced Budget Act of 1997 provides HCFA with the necessary tools to immediately reduce rates if there is compelling evidence that their rates exceed those generally being paid in the marketplace. We believe that this is the case here. If this authority is exercised for the four types of hospital beds surveyed, we estimate that annual savings at a 12 - 15 percent reduction would be approximately $32.7 to $40.9 million. Projected over 5 years, Medicare would save over $163 to $204 million.

We also believe that the payment method used by Medicare inappropriately overcompensates for rental use during the first 3 months of each rental period. We discuss this more thoroughly in our companion report, ***"Medicare Reimbursement for Hospital Beds in the Home: Payment Methodology" OEI-07-96-00222***. In that report we include a recommendation that HCFA seek legislation to correct that aspect of the problem. Overall, we believe that a combination of both approaches would be best. However, the savings would not be additive.

AGENCY COMMENTS

The HCFA concurs with the intent of our recommendation and is undertaking a comparison of hospital bed rates and a competitive bidding demonstration project as a prelude to making hospital bed rate changes. Appendix F contains the complete text of these comments. We remain available to provide technical assistance to HCFA on this matter.

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

Comparing Drug Reimbursement: Medicare and Department of Veterans Affairs

JUNE GIBBS BROWN
Inspector General

NOVEMBER 1998
OEI-03-97-00293

EXECUTIVE SUMMARY

PURPOSE

To compare Medicare allowances for prescription drugs with drug acquisition prices currently available to the Department of Veterans Affairs.

BACKGROUND

Medicare allowances for prescription drugs totaled almost $2.3 billion in 1996. In 1997, allowances rose to approximately $2.75 billion.

Medicare does not pay for over-the-counter or most outpatient prescription drugs. However, under specific circumstances, Medicare Part B covers drugs used with durable medical equipment or infusion devices. Medicare also covers certain drugs used in association with organ transplantation, dialysis, chemotherapy, and pain management for cancer treatment. Additionally, the program covers certain vaccines, such as those for influenza and hepatitis B.

Physicians and suppliers usually bill Medicare directly for the prescription drugs they provide to beneficiaries. Medicare Part B reimburses covered drugs at 95 percent of the drugs' average wholesale prices (AWPs). The beneficiary is responsible for a 20 percent coinsurance payment.

Unlike Medicare, the Department of Veterans Affairs (VA) purchases drugs for its healthcare system directly from manufacturers or wholesalers. There are several purchase options available to the VA, including the Federal Supply Schedule, Blanket Purchase Agreements, and VA national contracts.

We focused our inspection on 34 drug codes, each with over $10 million in Medicare allowed charges for 1996. We then compared the amount Medicare reimbursed for these drugs to the VA's Federal Supply Schedule acquisition costs during the first quarter of 1998.

FINDINGS

Medicare and its beneficiaries could save $1 billion in 1998 if the allowed amounts for 34 drugs were equal to prices obtained by the VA.

After comparing the median Medicare allowance with the corresponding median VA acquisition cost for 34 drugs, we estimated that Medicare and its beneficiaries could save $1.03 billion in 1998 if the Medicare allowed amounts for 34 drugs were equal to prices obtained by the VA under the Federal Supply Schedule.

This savings represents almost half of the $2.07 billion in reimbursement that Medicare and its beneficiaries paid for these 34 drugs in 1997. The estimated savings for individual drugs ranged from a high of $276 million for J9217 (leuprolide acetate) to a low of $16,460 for K0523 (concentrated metaproteranol sulfate).

Medicare allowed between 15 and 1600 percent more than the Department of Veterans Affairs paid for the 34 drugs reviewed.

The Medicare allowance was greater than the VA acquisition cost for every drug reviewed. For 3 of the 34 drugs, Medicare allowed more than 16 times the VA acquisition cost. Eleven drugs had Medicare allowances that were between two and six times higher than the VA cost. For only two drugs was the difference between Medicare reimbursement and VA cost less than 25 percent.

RECOMMENDATIONS

The Department of Veterans Affairs purchases drugs for its healthcare system directly from manufacturers or wholesalers. Conversely, Medicare reimburses doctors and suppliers for drugs which they administer or supply to beneficiaries. We recognize that the Health Care Financing Administration (HCFA) and the VA operate under different statutory constraints. Nevertheless, the fact remains that another Federal agency can get prescription drugs for a drastically lower price than Medicare.

Previous reports of the Office of Inspector General found that actual wholesale prices available to physicians and suppliers are often significantly lower than the Medicare allowed amounts. This report provides additional evidence that the published AWPs used in determining the Medicare allowed amounts for certain prescription drugs can be many times greater than the actual acquisition costs available in the marketplace.

We believe our current findings provide further support for recommendations made in earlier reports. We previously recommended that HCFA reexamine its Medicare drug reimbursement methodologies with the goal of reducing payments as appropriate. The HCFA concurred with this recommendation. We outlined a number of options for implementing this recommendation, including: (1) greater discounting of published average wholesale prices, (2) basing payment on acquisition costs, (3) establishing manufacturers' rebates similar to those used in the Medicaid program, and (4) using competitive bidding.

We continue to support the need for a comprehensive statutory reform of Medicare's prescription drug reimbursement methodology. A number of proposals addressing reform have been offered by both the Administration and members of Congress. However, until legislation can be enacted providing for such reform, we recommend that HCFA utilize the new inherent reasonableness or competitive bidding authorities provided in the Balanced Budget Act of 1997 to reduce Medicare's unreasonably high payments for certain drugs.

AGENCY COMMENTS

The HCFA concurred with our recommendations, stating that it appreciates the OIG's continuous efforts to assist it in obtaining the lowest prices for covered drugs. The HCFA noted that it has made several efforts to reduce excessive reimbursement rates, including using an inherent reasonableness adjustment for albuterol sulfate. The OIG supports these efforts and we believe HCFA should continue to use its inherent reasonableness authority to lower inappropriate payments for other drugs with excessive reimbursement rates.

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF PARTIAL HOSPITALIZATION SERVICES PROVIDED THROUGH COMMUNITY MENTAL HEALTH CENTERS

JUNE GIBBS BROWN
Inspector General

OCTOBER 1998
A-04-98-02146

DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Memorandum

Date OCT - 5 1998

From June Gibbs Brown
Inspector General

Subject Review of Partial Hospitalization Services Provided Through Community Mental Health Centers (A-04-98-02146)

To Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration

Attached is a copy of our final report entitled "Reviews of Partial Hospitalization Services Provided Through Community Mental Health Centers." This report provides you with a summary of audit activity on the delivery of mental health services through partial hospitalization programs (PHP) for Medicare beneficiaries at community mental health centers (CMHC) in Florida and Pennsylvania. The Office of Inspector General's (OIG) and the Health Care Financing Administration's (HCFA) work indicated widespread problems in this program. As you know, our offices have worked closely in reviewing this fast growing benefit area. We want to share with you our thoughts on possible actions that can be taken to address this problem issue of partial hospitalization services.

The Omnibus Budget Reconciliation Act of 1990 (OBRA 90) authorized Medicare coverage and payment of partial hospitalization services provided by CMHCs that are reasonable and necessary for the diagnosis and active treatment of an individual's mental condition in order to prevent a relapse or hospitalization. Joint reviews between HCFA staff and OIG offices in Florida and Pennsylvania showed that in 14[1] CMHCs:

- certification requirements to qualify as a CMHC were not always met;
- most of the beneficiaries were found to be ineligible for PHP services;
- many of the services provided to beneficiaries were not reasonable and necessary...nor were they eligible PHP services; and
- provider cost reports contained costs that were not always allowable, reasonable, and necessary.

[1]Subsequent to the issuance of our draft report, 6 additional HCFA reviews in Florida disclosed problems similar to those found in the 14 reviews of CMHCs (12 in Florida, 2 in Pennsylvania) reported herein. Five of the six facilities reviewed by HCFA are no longer in business.

Because localized approaches were used between our staffs in reviewing these 14 CMHCs, we are not able to provide an overall average error rate for these above noted error types. However, improper payments on behalf of ineligible beneficiaries or facilities that did not qualify as a CMHC totaled over $31 million for these 14 providers. The HCFA suspended Medicare payments to all 14 providers and terminated the provider numbers for 10 of the 12 facilities in Florida. Eleven of the 14 providers were referred to the OIG Office of Investigations for further analysis of their activities.

The OIG recently completed a review of PHP services in 5 States, representing about 77 percent of CMHC PHP payments nationally. This review was designed to determine the extent of ineligible beneficiaries enrolled in the program and provide input to HCFA on the reasonableness and necessity of the services provided by the CMHCs. The 5-State review disclosed that a substantial percentage of both claims and services were unallowable or highly questionable. The HCFA also recently completed a provider enrollment initiative in which on-site reviews were conducted at 700 CMHCs in 9 States. With the assistance of your office, we will also continue to target CMHCs around the country for individual reviews for eligibility and the allowability, reasonableness, and necessity of the costs reported on the cost reports.

This report presents our thoughts on changes that could be considered in an effort to eliminate the abusive practices being found in this program. We support: HCFA's efforts to develop a prospective payment system (PPS) for PHP services at CMHCs; the development of proposed rules that address surety bonds for CMHCs and the enrollment/re-enrollment process for CMHCs to participate in the Medicare PHP program; and HCFA's current 9-State enrollment initiative. As a PPS system is developed, we recommend that HCFA determine the costs of unnecessary care and other excessive costs (as shown in reviews completed thus far), and eliminate them from the cost data used to establish the PPS. We also offer the following recommendations for your consideration:

- Concerning the enrollment of ineligible providers, we suggest that HCFA either develop Conditions of Participation or conduct onsite surveys during the enrollment process to address qualifications issues. This would include compliance with laws and regulations including State licensure laws, furnishing appropriate services, and other patient health and safety issues.

- In regard to ineligible beneficiaries and services, we suggest that the fiscal intermediary (FI) perform a detailed review of the first claim for each new beneficiary receiving PHP services, including a review of medical records, and that HCFA, as part of its oversight activities, perform medical reviews of selected PHP claims.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

The Administrator
Washington, D.C. 20201

DATE: OCT 27 1998

TO: June Gibbs Brown
Inspector General

FROM: Nancy-Ann Min DeParle
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Fiscal Intermediary Fraud Units," (OEI-03-97-00350)

We welcome the suggestions in the above-referenced report that provides national information on the performance of fiscal intermediary fraud units. We appreciate OIG's efforts to help us strengthen the monitoring and oversight of fraud unit efforts.

The data collected for the report covered fiscal year (FY) 1996. Beginning in 1997, the Health Care Financing Administration (HCFA) mandated that fiscal intermediaries (FIs) use the HCFA Customer Information System as a fraud detection tool. The tool will enable the FIs to proactively identify fraud. In addition, during FY 1999, HCFA contractors will attend OIG regional training sessions that will further educate them about the proper development of cases to be referred to law enforcement agencies.

We concur with the report's recommendations. Our specific comments follow:

OIG Recommendation #1

HCFA should improve the contractor performance evaluation system so that it not only encourages continuous improvement, but also holds contractors accountable for meeting specific objectives.

HCFA Response

We concur and plan to develop specific national objectives to be evaluated during FY 1999. In September 1998, we visited 13 contractor fraud units to gather information that will help us develop ambitious, but practical, objectives. In addition, HCFA through its contractor has just completed gathering the requirements to be used in the design of a new program integrity management information system. The process required that the data metrics needed to evaluate Medicare contractor medical review and benefit integrity effectiveness be identified before building the new system. A contract has been let to build the new system.

OIG Recommendation #2
HCFA should require that all contractor performance evaluations list HCFA's national and regional objectives and address whether or not the fraud unit is meeting those objectives.

HCFA Response
We concur with the intent. The fraud unit contractor performance evaluation standards are being re-examined and will reference national objectives. Our regional offices have the authority to negotiate individual performance objectives with each contractor, so the creation of regional standards may not be necessary.

OIG Recommendation #3
HCFA should establish a standard set of data that can be used to measure fraud units' performance in meeting established objectives. Require that all contractor performance evaluation reports contain this data.

HCFA Response
We concur. In March 1998, HCFA identified and distributed a list of the most significant data metrics for regional office use in the FY 1998 contractor evaluation process. The development of national objectives will include the data metrics to be used in determining if objectives have been met.

OIG Recommendation #4
HCFA should establish clear definitions of key words and terms (e.g., complaint, case, program vulnerability, and overpayment). Disseminate definitions and require that HCFA program integrity staff and fraud unit staff use the same definitions. In a future update of the Medicare Intermediary Manual, revise sections so that these words are consistently used to mean the same thing.

HCFA Response
We concur. We will review the definitions of key words in our current Medicare Intermediary Manual. To the extent that we find inconsistencies, we will make appropriate revisions.

OIG Recommendation #5
HCFA should provide opportunities for fraud units to exchange ideas, compare methods, and highlight best practices relating to fraud and abuse detection.

HCFA Response

We concur. In March 1998, HCFA convened a national conference to identify best practices in fighting waste, fraud, and abuse. The conference brought together representatives from Medicare contractors, private industry, law enforcement, health care providers, and beneficiaries, in order to discuss ways to combat fraud. HCFA listened to these experts, and we are working to incorporate their effective methods into our own program integrity strategy.

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U.S. Department of Justice

Office of the Deputy Attorney General

Washington, D.C. 20530

FAX TRANSMISSION SHEET

TO: Chris Jennings

Phone: 456-5560 **Fax:** 456-6857

FROM: John T. Bentivoglio
Special Counsel for Health Care Fraud

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DATE: 1/4/99

NUMBER OF PAGES (including this cover sheet): 5

MESSAGE:

Note: The information in this facsimile should be considered confidential.

SEC.____. EXTENSION OF CRIMINAL PENALTIES FOR KICKBACKS.

Under current law (section 1128B(b) of the Social Security Act, 42 U.S.C. § 1320a-7b(b)), the anti-kickback provisions apply only to health care plans receiving federal funds, such as Medicare, Medicaid, and CHAMPUS. We are not aware of any justification for limiting sanctions against illegal kickbacks to Federal health care programs. Kickback schemes committed in connection with private health insurance plans result in the loss of millions of dollars each year and are contrary to the best interests of patients and the public. We believe that we should be able to proceed criminally against kickbacks committed against either public or private health plans, and this provision would provide us with the authority to do so.

hcf.sec
1/8/99
11:50 AM

$$\frac{1.2}{9.6} = \frac{X}{100}$$

$$120 = 9.6X$$

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

FISCAL INTERMEDIARY FRAUD UNITS

JUNE GIBBS BROWN - INSPECTOR GENERAL

AUGUST 1998

EXECUTIVE SUMMARY

PURPOSE

The purpose of this report is to provide national information on fiscal intermediary fraud units.

BACKGROUND

Fiscal intermediaries are companies under contract with the Health Care Financing Administration (HCFA) to administer a major part of the Medicare program. Individual fiscal intermediaries vary in many ways including the amount of claims and payments they process. Likewise, their fraud units differ from one another. But, all must meet requirements outlined in the Medicare Intermediary Manual. Fiscal intermediaries were responsible for $130 billion, or 75 percent, of total Medicare payments in 1996. The other 25 percent was handled by companies called carriers.

The HCFA requires that fiscal intermediaries and carriers have distinct units to detect and deter fraud and abuse. These units are part of HCFA's overall Medicare integrity program and are monitored by HCFA regional offices. The HCFA is currently planning to separate future anti-fraud functions from other intermediary and carrier operations. These activities will become the purview of a few contractors to be known as program safeguard contractors.

For this report, we surveyed all 41 fiscal intermediary fraud units that were under contract with HCFA in 1996 and still under contract in 1998. We collected fraud unit data for fiscal year 1996.

FINDINGS

Fraud units differed substantially in the number of complaints and cases handled. Some units produced few, if any, significant results.

While one would expect units of different size and resources to handle different size workloads, we found units of similar size and resources handling substantially different workloads.

- *Fraud units handled between 3 and 1,892 complaints per unit.*
- *The number of cases handled by each fraud unit ranged from 0 to 625.*
- *Fraud units referred between 0 and 102 cases to the Office of Inspector General.*

Despite HCFA's expectation that fraud units proactively identify fraud, half of the fraud units did not open any cases proactively.

More than one-third of fraud units did not identify program vulnerabilities.

Key words and terms related to fraud unit work vary in meaning. This hinders HCFA's ability to interpret fraud unit data and measure fraud unit performance.

RECOMMENDATIONS

The HCFA and fiscal intermediary fraud units have significant responsibilities in identifying and deterring fraud in a part of the Medicare program where $130 billion is at risk. The variation in fraud detection, especially among units with similar resources, raises concern about possible poor performance by some fraud units.

Although HCFA currently conducts performance evaluations of fraud units, we believe there is a need to strengthen the monitoring and oversight of contractors' efforts to identify fraud and abuse. In recent years, HCFA has focused on continuous improvement as a method of evaluating contractor performance. In light of the disparity in fraud detection among contractors, the agency may need to refocus its evaluation efforts to include some type of return on investment analysis.

In order that HCFA may have a better understanding of fraud unit performance, which in turn will lead to making better decisions about fraud unit funding, selecting future contractors, and working collaboratively with other anti-fraud entities, we recommend that HCFA:

- Improve the contractor performance evaluation system so that it not only encourages continuous improvement, but also holds contractors accountable for meeting specific objectives.

- Require that all contractor performance evaluations list HCFA's national and regional objectives and address whether or not the fraud unit is meeting those objectives.

- Establish a standard set of data that can be used to measure fraud units' performance in meeting established objectives. Require that all contractor performance evaluation reports contain this data.

- Establish clear definitions of key words and terms (e.g., complaint, case, program vulnerability, and overpayment). Disseminate definitions and require that HCFA program integrity staff and fraud unit staff use the same definitions. In a future update of the Medicare Intermediary Manual, revise sections so that these words are consistently used to mean the same thing.

- Provide opportunities for fraud units to exchange ideas, compare methods, and highlight best practices relating to fraud and abuse detection.

President's Medicare Fraud, Waste and Abuse Legislative Proposals

Eliminating Wasteful Excessive Medicare Reimbursement for Drugs

Proposal. Base Medicare's payment for drugs on the provider's actual acquisition cost of the drug instead of charges.

5-Year Savings: $690 million

Background. While Medicare does not have an expansive outpatient drug benefit, it does cover certain kinds of outpatient drugs, e.g., specific drugs that are used with home infusion or inhalant equipment, and drugs that are prescribed for dialysis and organ transplant patients. Medicare typically pays for these drugs based on the charge submitted by providers, usually physicians or pharmacies. Information from the HHS/OIG suggests that Medicare currently pays 15 to 30 percent more than what the provider paid for the drug.[1] The OIG has also reported that Medicare payments for drugs significantly exceed the Department of Veterans Affairs acquisition costs.[2]

Discussion. By basing Medicare's payment on the provider's acquisition cost of the drug, you eliminate payment for the mark-up which providers place on drugs.

Under the BBA, the Medicare payment limit for drugs is now 95 percent of the average wholesale price. Physician and pharmaceutical groups will be against this proposal because Medicare will be reimbursing them at a lower rate than it has in the past.

This proposal was included in the President's FY 1999 Budget.

Eliminating Overpayments for EPOGEN

Proposal. Reduce Medicare's reimbursement for EPO by $1.00 per dose.

5-Year Savings: $320 million

Background. EPO is a drug used to treat anemia related to chronic renal failure. It is a sole source drug, meaning that its manufacturer (Amgen) is competitively protected under the Orphan Drug Act. Medicare reimbursement for EPO totals nearly $1 billion per year. The HHS IG concluded in a 1997 that Medicare reimbursement for EPO should be reduced to reflect current

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[1] "Appropriateness of Medicare Prescription Drug Allowances" HHS/OIG, May 1996.

[2] "Comparing Drug Reimbursement: Medicare and Department of Veterans Affairs" HHS/OIG, November 1998

market prices[3]. The HHS IG report recommended that Medicare reduce payments to $9 per 1,000 units administered. This is a $1.00 reduction over Medicare's current payment rate of $10.00.

Discussion. This policy would reduce Medicare's reimbursement for EPO by $1.00 percent per dose and would capture the savings from the manufacturers rebate. Dialysis facilities, ESRD-related beneficiary groups and the manufacturer of EPO are likely to object to this change. This proposal was not included in the proposal to pay the acquisition cost for drugs because, unlike other drugs, we know exactly how much Medicare overpays for EPO. Therefore, rather than reducing payment to actual acquisition costs, this proposal cuts the payment by the amount Medicare is overpaying.

This proposal was included in the FY 1999 Budget.

Eliminating Abuse of Medicare's Partial Hospitalization Benefit

Proposal. Preclude providers from furnishing partial hospitalization services in a beneficiary's home or in clinically inappropriate settings such as an inpatient or nursing home. Provides the Secretary with broad authority to establish through regulation a prospective payment system for partial hospitalization services that reflects appropriate payment levels for efficient providers of service and payment levels for similar services in other delivery systems.

5-Year Savings: $120 million

Background. Currently, Medicare covers partial hospitalization services connected with the treatment of mental illness. Partial hospitalization services are covered only if the individual otherwise would require inpatient psychiatric. The course of treatment must be prescribed, supervised, and reviewed by a physician. The program must be hospital-based or hospital-affiliated and must be a distinct and organized intensive ambulatory treatment service offering less than 24-hour-daily care.

Partial hospitalization services include individual and group therapy sessions, occupational therapy, services of social workers, drugs and biologicals, family counseling and diagnostic services.

Discussion. This proposal would discourage partial hospitalization programs targeted to patients in their homes or in settings where there is a residential population, such as nursing facilities and assisted living facilities. The HHS/OIG has found large abuses in Medicare's outpatient mental health benefits including billing for services provided in group settings that are unnecessary or

[3] "Review of EPOGEN Reimbursement" HHS/OIG, November 1997.

inappropriate[4].

The partial hospitalization benefit was intended to be a less-costly alternative to inpatient psychiatric care. The current reasonable cost reimbursement methodology has resulted in excessive payment and inappropriate payment for items and services that are excluded from the definition of partial hospitalization services.

This proposal was in the FY 1999 Budget

Ensure Medicare does not Pay for Claims Owed by Private Insurers

Proposal. Require Medicare's contractors to match their enrollment records with Medicare's on a real-time basis to ensure (before a claim is paid) that Medicare is not paying when private payers are liable.

5-Year Savings: $690 million

Background. Currently, Medicare is prohibited from requiring its contractors -- most of whom are commercial insurance companies or Blue Cross/Blue Shield plans -- to share data on their commercial enrollee populations to identify situations in which Medicare is the secondary, rather than primary payer. In other words, Medicare's contractors, in some situations, are paying claims on behalf of Medicare that the contractor knows it is responsible for paying as a private company. The contractor then waits to be "caught" by the normal matching process (which may take up to five years) before it re-pays Medicare.

Discussion. In the fight against fraud and abuse, Medicare secondary payer checks are important. HCFA estimates that the return on investment for this activity is 26:1. This proposal would increase this return on investment by decreasing the cost to Medicare of undertaking this activity. Currently, there is no incentive for contractors to identify situations in which Medicare might be secondary payer because the contractor may actually be the primary payer. This proposal would eliminate the need for an incentive. Insurance companies that currently contract with Medicare will be opposed this proposal.

This proposal was included in the FY 1999 Budget.

Enable Medicare to Capitate Payments for Certain Routine Surgical Procedures Through a Competitive Pricing Process with Providers

Proposal. Expand the current HCFA Centers of Excellence demonstration which enables

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[4] "Review of Partial Hospitalization Services Provided Through Community Mental Health Centers" HHS/OIG, October 1998

Medicare to negotiate payment rates for certain routine surgical procedures through a competitive bidding process with providers in exchange for assured market share. The demonstration would be expanded from 10 states to include all urban areas.

5-year savings: $560 million

Background. Currently, HCFA is conducting a demonstration that will pay facilities in 10 states, considered to be "centers of excellence" a flat fee for coronary artery bypass graft (CABG) surgery or other heart procedures, knee surgery, hip replacement surgery, and other procedures that the HHS Secretary determines to be appropriate.

Providers will negotiate with HCFA a flat payment to cover all of the costs (hospitals and physicians) associated with the procedure. HCFA expects up to 100 total facilities to participate in the current demonstration. This demonstration developed from a smaller HCFA demonstration during the early 1990s of seven sites that performed CABG and cataract surgery. An independent evaluation determined that, on average, the flat payment mechanism resulted in reduced costs to the Medicare program without any change in the health status of patients who receives care from these centers. The Administration supported expanding the demonstration in the Balanced Budget Act; however, the provision was dropped from the conference agreement.

Discussion. Even though the Medicare program is the largest purchaser of medical care in the US, it does not receive volume discounts like other large purchasers. At the same time, hospitals may not have enough patients to become more proficient providers of care and thus be able to offer the highest quality of care to beneficiaries. The Centers of Excellence demonstration is intended to enable the Medicare program to receive volume discounts on routine surgical procedures and, in return, enable hospitals to increase their market share and gain clinical expertise.

Expanding the demonstration may incur resistance from some providers. Even though the demonstration does not require patients to receive care at participating facilities, expanding it further may split the market for these procedures. Providers who are not likely to be selected to participate would argue that they would lose market share of the demonstration were expanded.

This proposal was included in the FY 1999 Budget.

PRESIDENT CLINTON UNVEILS LEGISLATIVE AND ADMINISTRATIVE PROPOSALS TO FIGHT MEDICARE FRAUD, WASTE, AND ABUSE
December 7, 1998

Today, President Clinton announced additional steps to fight fraud, waste, and abuse in the Medicare program, building on the Administration's longstanding efforts in this area. The President unveiled a legislative package that will save Medicare over $2 billion. He also announced new administrative measures to crack down on fraud, including efforts to make Medicare contractors more effective and accountable. Today in an event with the Administrator of the Health Care Financing Administration (HCFA), the HHS Inspector General, Senator Tom Harkin, and the Older Women's League, the President:

ANNOUNCED NEW LEGISLATIVE PACKAGE THAT WILL SAVE MEDICARE OVER $2 BILLION BY COMBATING FRAUD, WASTE, AND ABUSE. President Clinton will send Congress a comprehensive legislative package to fight fraud, waste, and abuse in the Medicare program as part of his FY2000 budget proposal. These proposals, which are consistent with recommendations made by the HHS Office of the Inspector General (OIG) in recent reports and some of which have been recommended to Congress before, will give HCFA more tools to root out fraud, abuse, and waste in Medicare. The proposals include:

- **Eliminating Excessive Medicare Reimbursement for Drugs.** A recent report by the OIG confirmed that Medicare currently pays hundreds of millions of dollars more for 22 of the most common and costly drugs than it would if it used market prices. For more than one-third of these drugs, Medicare paid more than double the average wholesale price, and in one case paid ten times the amount. This proposal would base Medicare payments on the actual acquisition cost of these drugs to the provider, eliminating current mark-ups and thereby substantially reducing Medicare costs.

- **Ending Overpayments for Epogen,** a drug used to treat anemia related to chronic renal failure. An OIG report found that the current reimbursement rate of $10 per 1,000 units of Epogen exceeds the current cost of the drug by approximately 10 percent. The Administration's proposal reduces Medicare reimbursement to reflect current market prices.

- **Preventing Abuse of Medicare's Partial Hospitalization Benefit.** A recent OIG report found that providers are abusing Medicare by billing for partial hospitalization services that were never given or provided to many fewer patients than were billed for. This proposal would ensure that Medicare reimburses only for services actually given by placing stricter controls on the provision of these services.

- **Ensuring Medicare Does Not Pay for Claims Owed by Private Insurers.** Private insurers of working Medicare beneficiaries are required under law to be the primary payor of health claims. These insurers, however, do not always pay the claims for which they are responsible. This proposal prevents this abuse by requiring private insurers to report all Medicare beneficiaries they insure to HCFA. This proposal also would give HCFA greater authority to fine private insurers, including the authority to recoup twice the amount owed if insurers intentionally allow Medicare to pay claims for which they are responsible.

- **Empowering Medicare to Purchase Cost-Effective High-Quality Health Care.** Medicare now has limited demonstration authority to contract out with institutions that have a track record of providing exceptionally high-quality care at a reasonable price, called centers of excellence. This proposal would expand this authority to urban areas that have multiple providers, thereby enabling the Medicare program to provide higher quality health care at less cost.

- **Requesting New Authority to Enhance Contractor Performance.** HCFA still does not have the authority it needs to terminate more expeditiously contractors who do not effectively perform their duties. This proposal would give HCFA authority to contract with a wider range of carriers to administer the program, and then to terminate them if they fail to perform effectively. The proposal would give HCFA greater authority to oversee contractor performance of such functions as enrolling providers, investigating fraud, and collecting overpayments.

TOOK NEW ACTIONS TO HELP ENSURE MEDICARE CONTRACTORS FIGHT FRAUD, WASTE, AND ABUSE. Today, the President is also unveiling new administrative efforts to ensure contractors are cracking down on fraud and abuse. These include:

- **Contracting with Special Fraud Surveillance Units to Ensure Detection of Fraudulent Activities.** OIG reports have shown that many Medicare contractors do a poor job of investigating fraud, in part because they have a wide variety of other functions, and in part because they have multi-faceted relationships with providers that may create conflicts of interest. The Administration fought to include in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) new authority to contract with specialized fraud, waste, and abuse surveillance units or "fraud fighters," which are better equipped to audit cost reports and conduct activities that are vital to the detection of fraud, waste, and abuse. The first fraud surveillance units will begin their efforts this spring.

- **Implementing the Competitive Bidding Demonstration for Durable Medical Equipment.** The OIG recently found that Medicare rates for hospital beds are substantially higher than rates paid by other payers. HCFA will begin a demonstration this spring that will use competitive bidding to decrease Medicare payment for hospital beds and other durable medical equipment, thereby lowering program costs.

- **Requiring Contractors to Report Fraud Complaints to the Inspector General Right Away.** Many contractors now defer reporting cases of suspected fraud to the OIG when the dollar amounts are low, even though these reports could show significant patterns of fraud. This month, HCFA will send program memorandums to all contractors requiring them to refer suspected fraud to OIG immediately, regardless of the amounts involved.

- **Announcing That A New Comprehensive Plan to Fight Fraud and Abuse Will Be Completed By Early Next Year.** To improve efforts to cut down on fraud and abuse, HCFA will release a new Comprehensive Plan for Program Integrity early next year. This plan will outline new strategies to fight fraud, including enhanced use of audits and improved management tools.

BUILDING ON LONGSTANDING COMMITMENT TO FIGHTING FRAUD, WASTE, AND ABUSE. The new steps the President took today build on the Administration's longstanding commitment to crack down on fraud, waste, and abuse. Since 1993, the Administration's efforts have saved taxpayers more than $20 billion, with health care fraud convictions increasing by more than 240 percent. The Administration has assigned more federal prosecutors and FBI agents to fight health care fraud than ever before. HIPAA created, for the first time ever, a stable funding source to fight fraud and abuse, and in FY1997 alone -- the first full year of funding under HIPAA -- nearly $1 billion in fraud and abuse savings was returned to the Medicare Trust Fund.