Laboratories—Reinstate Beneficiary Cost Sharing and Notices for Lab Tests and Evaluate the Fee Schedule for Lab Services

Recommendations To Be Implemented

We recommend that CMS

- reinstate beneficiary deductibles and coinsurance (and notifications of amounts paid on their behalf) as a means of controlling utilization and
- periodically evaluate the national fee schedule to ensure that reimbursement is aligned with the prices that physicians pay for clinical laboratory tests.

Savings – The Congressional Budget Office's (CBO) December 2008 "*Budget Options Volume I – Health Care*" (p. 159) estimated savings of $23.8 billion over 10 years from reinstating standard deductible and coinsurance requirements, with annual savings of $2.4 billion by 2014.

The recommendations would help prevent the wasteful Medicare spending known to occur because beneficiaries do not share in the cost of laboratory tests. Medicare pays for allowed laboratory charges at a rate of 100 percent, which is unlike its reimbursement rate for most other Medicare benefits.

Waste also occurs because Medicare's fee schedule methodology does not align reimbursements with the prices that physicians pay for clinical laboratory tests.

Beneficiary cost sharing is a standard provision of the Medicare program. A January 1996 OIG report said that if laboratory tests were subject to Medicare's deductible and the 20-percent coinsurance and beneficiaries received a notice of the amount paid on their behalf, there would be more participatory control over utilization and billing. CMS informally confirmed in 2011 that because beneficiaries do not pay a share of the charges, CMS has no global policy requiring its payment contractors to notify beneficiaries of the payments Medicare made to laboratories on their behalf. Notifications are an important program integrity safeguard.

With regard to reimbursements, a January 1990 OIG report noted that Medicare was paying substantially more than physicians paid for laboratory tests. Our detailed review of 4,120 billings to 211 physicians revealed that the Medicare payment rates were about 90 percent more than the amounts that were actually paid by physicians. The January 1996 report said that although Medicare reduced the national fee schedule after our 1990 report, the average amount billed per beneficiary had gone up.

The Medicare Improvement for Patients and Providers Act of 2008 (MIPPA), § 145(b) made adjustments to the laboratory reimbursement methodology, but did not resolve our concerns.

Progress of Implementation

Copayments—CMS said a legislative change would be necessary to reinstate deductibles and coinsurance.

- In December 2008, the Congressional Budget Office (CBO) estimated that $23.8 billion could be saved over 10 years by reinstating standard deductible and coinsurance requirements through an option that would require independent laboratories to bill the providers who ordered the tests instead of billing Medicare and the enrollees separately. Providers, who already bill and collect fees from patients, would bill Medicare and collect the beneficiary copayments.
- The December 2008 option places the ordering physician (instead of laboratories) at the hub of Medicare billing for lab tests, and restoring deductibles and copayments would raise beneficiaries' awareness of claims filed on their behalf. *Budget Options, Volume 1: Health Care*. Option 86. "Impose a Deductible and Coinsurance for Clinical Laboratory Services Covered by Medicare," p. 159.

Reimbursements—With regard to reevaluating the fee schedule, CMS said it did not have access to physician or laboratory records that would enable it to determine the prices that laboratories charge other customers or the amounts that physicians are paying for laboratory tests. CMS noted in its annual updates that it was taking steps to reduce payments for laboratory tests and said it would continue to evaluate payment levels for laboratories. CMS has not provided specific information that would cause us to close out our recommendation on reimbursements.

- An October 14, 2011, MedPAC package of potential policies to offset the budgetary costs of repealing the sustainable growth rate system estimated that reducing clinical laboratory payments by 10 percent would save $10 billion over 10 years.
- The Middle Class Tax Relief and Job Creation Act of 2012, § 3202, reduced by 2 percent the fee schedules for 2013, and such reduced fee schedules will serve as the base for 2014 and subsequent years. According to a joint staff analysis of the House Committees on Ways and Means and Energy and Commerce, CBO estimated that § 3202 will reduce spending by $2.7 billion over 10 years.

We encourage CMS to seek legislative authority to reinstate deductibles and copayments and, as it reviews billing patterns for codes for more complex lab tests, to consider appropriate adjustments to be made to reimbursements, seeking legislation if necessary.

Primary OIG Reports

1996 JAN *Follow-up to Report on Changes Are Needed in the Way Medicare Pays for Clinical Laboratory Tests.* A-09-93-00056. January 1996. Full Text.

1990 JAN *Changes Are Needed in the Way Medicare Pays for Clinical Laboratory Tests.* A-09-89-00031. Full Text.

See Also

2012 JUN *Medicare Memorandum Report: Coverage and Payment for Genetic Laboratory Tests*. OEI-07-11-00011. Full Text.

Laboratories—Establish a New Process for Reimbursement of Laboratory Tests

Recommendation To Be Implemented

- We recommend that CMS seek legislative authority to establish a new process for setting accurate and reasonable payment rates for laboratory tests.

Savings probable but not estimated.

The recommendation would curb the questionable Medicare spending that is occurring because the data used in 1985 to establish and update the Clinical Laboratory Fee Schedule may not have reflected the actual costs of performing the lab tests. Also, the data may not have reflected real differences in costs from one geographic area to another, as would be expected.

A July 2009 OIG report indicated that in establishing rates in 1985, carriers used data on laboratory charges that may not have reflected costs. Since then, methods used to update carrier rates have incrementally added to variation in carrier rates. If CMS continues to use current methods for updating the Clinical Laboratory Fee Schedule, early formula calculations that do not reflect actual costs will remain and possibly increase over time. Therefore, a new process is needed for setting accurate and reasonable payment rates that would represent costs, adjusted for geographic differences.

Under current methodology, Medicare's payment contractors reimburse laboratories the lower of the laboratories' charges or the contractors' fee schedules for their geographic areas for each test, as capped by a national limit amount (NLA).

Progress of Implementation

CMS said it would consider our recommendation as it continues to monitor the effects of its payment policies for laboratories. Options may include instituting competitive bidding for laboratory services.

The HHS Budget in Brief for Fiscal Year 2009 proposed introducing competitive bidding for clinical laboratory services (p. 54). Specifically it proposed to expand the successful competitive acquisition policy to include clinical laboratory services. HHS estimated the savings at $2.29 billion over 5 years, 2009–2013, p. 59.

We encourage CMS to continue to pursue legislation that would set accurate and reasonable payment rates for laboratory tests.

Primary OIG Report

2009 JUL *Variation in the Clinical Laboratory Fee Schedule.* OEI-05-08-00400. Full Text.

See Also

2002 JAN *Common Working File Edits for Unauthorized Laboratory Tests*. OEI-05-00-00050. Full Text.

1996 JAN *Follow-up to Report on Changes Are Needed in the Way Medicare Pays for Clinical Laboratory Tests.* A-09-93-00056. January 1996. Full Text.

1990 OCT *Ensuring Appropriate Use of Laboratory Services*. OEI-05-89-89150. Full Text.

1990 JAN *Changes Are Needed in the Way Medicare Pays for Clinical Laboratory Tests.* A-09-89-00031. Full Text.

1989 MAR *Medicare Reimbursement for Outpatient Laboratory Services*. OAI-04-88-01080. Full Text.

Medicare A/B > Avoid Waste in Spending > Medical Equipment > Oxygen Rental Period

Medical Equipment—Reduce the Rental Period for Home Oxygen Equipment

Recommendation To Be Implemented

- We recommend that CMS work with Congress to further reduce the rental period for oxygen equipment.

Savings – We calculated that if the rental period were 13 months instead of 36 months, Medicare and its beneficiaries would save approximately $3.2 billion over 5 years. The Congressional Budget Office estimated savings at $11 billion over 10 years. (See "Progress" section.)

The recommendation would curb the wasteful Medicare spending that occurs because Medicare's and beneficiaries' expenditures for rented oxygen equipment substantially exceed the purchase price of the equipment.

At the end of the capped rental period, ownership of the oxygen equipment transfers to the beneficiary. The current 36-month rental period causes excessive rental payments to occur prior to transfer of ownership.

A September 2006 OIG report estimated that Medicare would allow $7,215 for 36 months for concentrators that cost only $587, on average, to purchase. Beneficiaries would pay $1,443 in coinsurance paid for the same $587 concentrators. The beneficiaries' coinsurance alone exceeds the average cost of two concentrators by $269. A legislative change is needed to reduce the rental period.