Memorandum

Date JUN - 7 2000

From For June Gibbs Brown
Inspector General

Subject Medicare Program; Expanded Coverage of Outpatient Diabetes Self-Management Training Services (A-14-99-00207)

To Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration

Attached is a copy of our final report entitled, "Medicare Program; Expanded Coverage of Outpatient Diabetes Self-Management Training Services." The objective of our review was to assess the reasonableness of the individual and group session payment rates proposed by the Health Care Financing Administration (HCFA) for outpatient diabetes self-management training (DSMT) services. The Balanced Budget Act of 1997 expanded coverage for outpatient DSMT services furnished by non-hospital-based programs and required that the payment amounts for DSMT services be established after consultation with appropriate organizations.

While we acknowledge that HCFA attempted to develop reasonable payment rates within strict time constraints, we are concerned that the proposed payment rates for both individual and group sessions are not reasonable. At the time of the Departmental clearance of the Notice of Proposed Rulemaking (NPRM) on this issue, we had limited information on which to base a conclusion that the NPRM needed changes. Based on our analysis since that time, however, we believe the proposed individual and group session payment rates are inflated because of two issues.

- Both the proposed individual and group session payment rates were inflated because they include calculation errors. Based on our analysis, Medicare could make improper payments totaling $50 million for the 4-year period (Fiscal Years 2000 through 2003) due to simple calculation errors. Because Medicare deductibles and co-payments would also apply for these services, Medicare beneficiaries will also be adversely affected by the inflated payment rates. Improper Medicare beneficiary co-payments totaling $12.5 million would result during the same 4-year period if the payment rates are not adjusted downward.

- The HCFA's group session payment rate appears to be substantially higher than that being charged in the marketplace. This conclusion was based on our

comparison of HCFA's proposed group session payment rate to actual group session DSMT program rates at several providers we either visited or for which we obtained data. We also found significant differences between HCFA's proposed rate and the actual cost of DSMT programs at two Maryland hospital-based providers. Applying these significant payment differences to all anticipated group session training hours indicates that the Medicare program and its beneficiaries could pay substantially more for this training than warranted.

We also believe that the payment rates will continue to be excessive if HCFA uses them as the planned baseline when incorporating DSMT services into the Medicare physician fee schedule.

Subsequent to our issuance of our draft report, we examined the impact of the interim DSMT rates on 1999 Medicare payments. Although the calculation errors resulted in a minimal amount of excessive Medicare payments for 1999, the impact on future payments could be extensive. In 1999 there were less than $2 million paid for DSMT services instead of the $390 million anticipated.

We recommended that HCFA further review the rates contained in the proposed rule. At a minimum, the rates should be adjusted downward to correct the calculation errors we note in our review. We will provide HCFA officials with the details of our review for use in adjusting the payment rates. We would also be willing to work with HCFA to perform any additional studies deemed appropriate to obtain better cost data on DSMT services so that accurate base year costs could be developed.

In its response to our draft report, HCFA commented that it did not concur with our recommendations. The HCFA stated that the rates are based on resource-based relative value units that reflect work, practice expenses, and malpractice expenses, and the rates will be refined as additional experience and knowledge is gained. The HCFA disagreed that Medicare would achieve savings by making the Office of Inspector General (OIG) recommended revisions due to the budget neutrality provision of the physician fee schedule. The HCFA also made technical comments regarding some of the costs that we questioned. Finally, HCFA believed that the OIG revised amounts may compromise the quality of the DSMT program. The full text of HCFA's response is included as Appendix D.

Based on our analysis, we still believe that the rate assigned by HCFA exceeds the resources needed for DSMT services. We believe the most opportune time to refine the payment rates for DSMT services is before the rates are finalized. Also, the timeliness of making the refinements is critical to saving the Medicare program and its beneficiaries millions of dollars. We believe that the budget neutral provision allows HCFA the latitude to make an adjustment for DSMT services under section 1848(c)(2)(B)(ii) as either a new procedure and/or as new data on the relative value components. In addition, the annual recommended adjustment is less than the $20 million threshold. As such, we continue to recommend that

HCFA further review the payment rates contained in the NPRM and consider adjusting them. At a minimum, the rates should be adjusted downward to eliminate calculation errors found in our review.

We do, however, acknowledge that HCFA has raised some good points in their comments. We plan, therefore, to expand our work in this area into a national study of the training services being rendered. We plan to have the results of this review completed by late summer of 2000. We suggest that if HCFA has to finalize the proposed rule on this issue before our work is completed, then HCFA may want to acknowledge in the final rule that the OIG is performing some additional work and the rates may be modified at a later date.

We would appreciate your views and the status of any action taken or contemplated on our recommendations within the next 60 days. If you have any questions, please contact me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits at (410) 786-7104.

To facilitate identification, please refer to Common Identification Number A-14-99-00207 in all correspondence relating to this report.

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE PROGRAM; EXPANDED COVERAGE OF OUTPATIENT DIABETES SELF-MANAGEMENT TRAINING SERVICES

JUNE GIBBS BROWN
Inspector General

JUNE 2000
A-14-99-00207

Memorandum

Date JUN - 7 2000

From for June Gibbs Brown
Inspector General

Subject Medicare Program; Expanded Coverage of Outpatient Diabetes Self-Management Training Services (A-14-99-00207)

To Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration

This report provides you with our concerns on the Health Care Financing Administration's (HCFA) development of payment rates for Medicare's expanded coverage of outpatient diabetes self-management training (DSMT) services. The Balanced Budget Act (BBA) of 1997 expanded coverage for outpatient DSMT services furnished by non-hospital-based programs and required that the payment amounts for DSMT services be established after consultation with appropriate organizations. The objective of our review was to assess the reasonableness of the individual and group session payment rates proposed by HCFA for outpatient DSMT services.

While we acknowledge that HCFA attempted to develop reasonable payment rates within strict time constraints, we are concerned that the proposed payment rates for both individual and group sessions are not reasonable. At the time of the Departmental clearance of the Notice of Proposed Rulemaking (NPRM) on this issue, we had limited information on which to base a conclusion that the NPRM needed changes.

Although our review was limited in order to respond to HCFA during the comment period, we found that:

- the proposed individual and group session payment rates for DSMT services were unreasonable,
- the payment rates will continue to be excessive if HCFA uses them as a baseline when incorporating DSMT services into the Medicare physician fee schedule (MPFS), and
- additional data needs to be gathered before the rule is implemented in final.

Subsequent to our issuance of our draft report, we examined the impact of the interim DSMT rates on 1999 Medicare payments. Although the calculation errors resulted in a

minimal amount of in excessive Medicare payments for 1999, the impact on future payments could be extensive. In 1999 there were less than $2 million paid for DSMT services instead of the $390 million anticipated.

OBJECTIVE

Are the proposed individual and group session payment rate calculations correct?

FINDING

Both the proposed individual and group session payment rates were inflated because they include calculation errors. Based on our analysis, Medicare could make improper payments totaling $50 million for the 4-year period (Fiscal Years (FY) 2000 through 2003) due to simple calculation errors. Because Medicare deductibles and co-payments would also apply for these services, Medicare beneficiaries will also be adversely affected by the inflated payment rates. Improper Medicare beneficiary co-payments totaling $12.5 million would result during the same 4-year period if the payment rates are not adjusted downward. We also found that the proposed rates include costs that should have been allocated to other programs; however, we did not have enough information to determine the related improper payments.

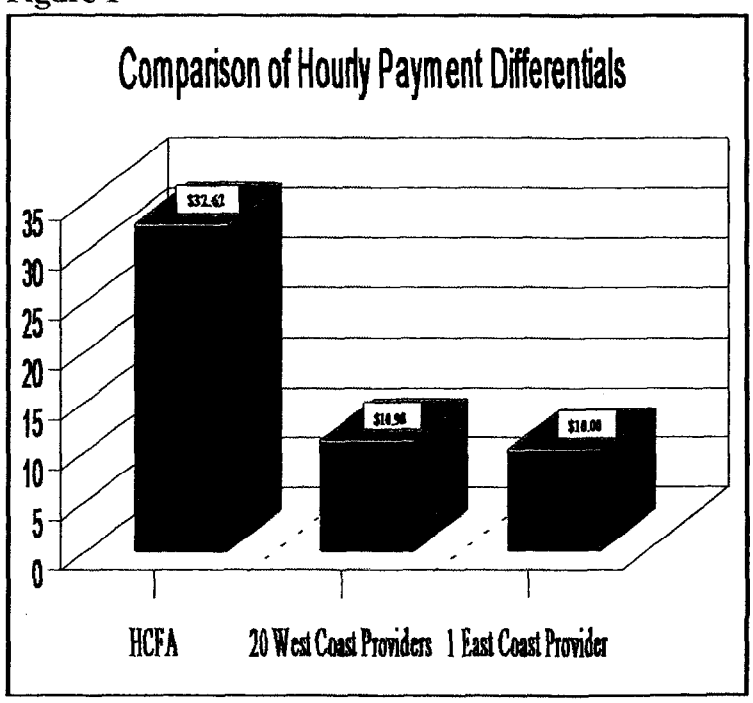
OBJECTIVE

Are the group session payment rates comparable to existing Medicare charges for similar services?

FINDING

The HCFA's group session payment rate appears to be higher than that being charged in the marketplace based on our analysis of actual payment rates at several providers (see Figure 1). We compared HCFA's proposed group session rate ($32.62) to other group session rates charged in the Washington State area. Based on Medicare's reasonable cost reimbursement principles, the average session rate for 20 providers was $10.98. We also compared HCFA's proposed rate to one Maryland provider which had a $10.00 per hour session rate.

Figure 1



OBJECTIVE

Are the individual cost elements from the group session payment rate comparable to selected cost at other providers offering similar services?

FINDING

The HCFA's group session payment rate appears to be substantially higher than the actual operating costs of providing such training based on our analysis of DSMT programs at two providers. We found significant differences between HCFA's proposed rate (based on the American Diabetes Association's (ADA) data at two hospital-based providers - one on the east coast and one in the mid-west) and the actual cost of DSMT programs at two Maryland hospital-based providers. Because of the wide disparity between provider costs and the significant impact on the Medicare Trust Funds (based on a national estimate of almost 20 million hours of group session training being reimbursed by Medicare), we believe that additional cost analysis is needed before the payment rate is finalized.

We recommended that HCFA further review the rates contained in the proposed rule. At a minimum, the rates should be adjusted downward to correct the calculation errors we note in our review. We will provide HCFA officials with the details of our review for use in adjusting the payment rates. We would also be willing to work with HCFA to perform any additional studies deemed appropriate to obtain better cost data on DSMT services so that accurate base year costs could be developed.

In its response to our draft report, HCFA commented that it did not concur with our recommendations. The HCFA stated that the rates are based on resource-based relative value units (RVU) that reflect work, practice expenses, and malpractice expenses, and the rates will be refined as additional experience and knowledge is gained. The HCFA disagreed that Medicare would achieve savings by making the Office of Inspector General (OIG) recommended revisions due to the budget neutrality provision of the physician fee schedule. The HCFA also made technical comments regarding some of the costs that we questioned. Finally, HCFA believed that the OIG revised amounts may compromise the quality of the DSMT program. The full text of HCFA's response is included with this report as Appendix D.

The proposed rule was to set forth the payment amounts for the DSMT program under the MPFS (based on the RVU system). The value of the RVU should be based on the resources needed to furnish the service. Based on our analysis, we still believe that the rate assigned by HCFA exceeds the resources needed for DSMT services. We believe the most opportune time to refine the payment rates for DSMT services is before the rates are finalized. Also, the timeliness of making the refinements is critical to saving the Medicare program and its beneficiaries millions of dollars. We believe that the budget neutral provision allows HCFA the latitude to make an adjustment for DSMT services under section 1848(c)(2)(B)(ii) as

either a new procedure and/or as new data on the relative value components. In addition, the annual recommended adjustment is less than the $20 million threshold. As such, we continue to recommend that HCFA further review the payment rates contained in the NPRM. At a minimum, the rates should be adjusted downward to eliminate calculation errors found in our review. We have also modified our report to address HCFA's technical comments.

We do, however, acknowledge that HCFA has raised some good points in their comments. We plan, therefore, to expand our work in this area into a national study of the training services being rendered. We plan to have the results of this review completed by late summer of 2000. We suggest that if HCFA has to finalize the proposed rule on this issue before our work is completed, then HCFA may want to acknowledge in the final rule that the OIG is performing some additional work and the rates may be modified at a later date.

BACKGROUND

In 1997, as reported by the Department of Health and Human Services' Centers for Disease Control and Prevention, nearly 15.7 million people in the United States (U.S.) had diabetes, almost 6 percent of the population. Among Americans aged 65 and older, 4 million persons (9.3 percent of this group) are estimated to have diabetes, with as many as 18.7 percent at risk for developing diabetes. In the U.S., diabetes is the leading cause of blindness, lower extremity amputations, kidney disease requiring dialysis, and the seventh leading cause of death. Diabetes and its complications are primary or secondary factors in an estimated 9 percent of hospitalizations. Overall, beneficiaries with diabetes are hospitalized 1.5 times more often than beneficiaries without the disease. Ten percent of these hospitalizations are a direct result of uncontrolled diabetes, and more than half of these admissions occur in beneficiaries 65 and older.

Since 1994, Medicare payment for diabetes education was limited to services furnished in the hospital outpatient department to the hospital's registered outpatients. These services were paid under Medicare Part B on a reasonable cost basis. In all other Medicare settings, beneficiary education related to diabetes was treated as an integral part of a direct service if furnished by a physician or nonphysician practitioner or furnished as incident to their services and no separate charge was allowed.

Section 4105(a) of BBA of 1997 (Public Law 105-33, enacted on August 5, 1997) expanded coverage for outpatient diabetes self-management training services furnished by non-hospital-based programs. The proposed rule implementing DSMT expanded coverage was published in the Federal Register on February 11, 1999 (see 64 FR 6827). Under the proposed rule:

> *"...training would include educational and training services furnished in an outpatient setting (according to frequency standards established by the Secretary) to a beneficiary with diabetes by a "certified provider" that meets certain quality standards. These services would be covered only if the physician managing the beneficiary's diabetic condition certifies that the services are needed under a comprehensive plan of care in order to provide the beneficiary with the skills and knowledge necessary to help manage his or her diabetes. Services would be paid under the Medicare physician fee schedule in amounts established by the Secretary after consultation with appropriate organizations...."*

The goals in the management of diabetes are to achieve normal metabolic control and reduce the risk of complications. In expanding the Medicare program to include outpatient diabetes self-management training services, the Congress intended to empower Medicare beneficiaries with diabetes to better manage and control their conditions. The Conference Report indicated that the conferees believed that:

> "This provision will provide significant Medicare savings over time due to reduced hospitalizations and complications arising from diabetes."

The rule also set forth proposed payment amounts for both individual and group sessions that were effective July 1, 1998. Group training sessions would consist of 2 to 20 individuals (not all have to be Medicare eligible). Individual training sessions are covered if no group session is available within 2 months of the physician's order, or if the beneficiary is certified as having special needs. Medicare will cover up to 10 hours of initial training within a continuous 12-month period for a qualified beneficiary. Beneficiary co-payments are set at 20 percent of the MPFS.

SCOPE OF REVIEW

The objective of our review was to assess the reasonableness of the individual and group session payment rates proposed by HCFA for outpatient DSMT services. To accomplish our objective, we:

- reviewed the subject notice of proposed rule making as published in the Federal Register,
- reviewed how the proposed payment rates were developed,
- reviewed HCFA's process to refine the proposed rates,
- reviewed how the ADA advisory group derived its estimated resource costs,

- visited two hospital-based diabetes self-management training programs in Baltimore, Maryland to obtain information on the actual cost of providing such training,
- reviewed a Washington State Diabetes Reimbursement Survey,
- computed the effect of improper payments based on actual utilization for Calendar Year (CY) 1999[1], and
- computed the effect of improper payments for FY 2000 through FY 2003 based on the utilization parameters from FY 1999 through FY 2002 as set forth in the proposed rule.[2]

Our review primarily focused on the establishment of the group session payment rate because, according to the proposed regulation and actuarial estimates, it should be the predominant delivery mode of training.

It is important to note that, in deriving the recommended payment amounts, OIG used information provided by HCFA staff and the accepted theories, methods, and/or assumption published in the NPRM for various cost categories.

Our limited-scope review was made in accordance with generally accepted government auditing standards. The work was performed during September 1998 through April 2000 in Baltimore, Maryland at HCFA's central office and two hospital-based outpatient self-management training programs.

RESULTS OF REVIEW

Overall, our review found that the payment rates established for DSMT for both individual and group sessions do not appear reasonable. We concluded that both the proposed individual and group session payment rates were inflated because they include calculation errors. In addition, HCFA's group session payment rate was substantially higher than that being charged in the marketplace based on our limited analysis of available actual payment rates. The HCFA's group session payment rate was substantially higher than the actual operating costs of DSMT programs at two providers. Moreover, we are concerned that these payment rates will continue to be excessive if HCFA uses them as a baseline when

[1]Based on the Part B data files as of April 2000.

[2]Since the proposed rule was not published until February 1999, we believe the utilization levels projected in the NPRM will be achieved later than estimated. The anticipated 7.8 million billing hours for group sessions in the first year never materialized.

incorporating DSMT services into the MPFS. We believe that more time is needed to gather and analyze data to develop more accurate payment rates.

Our review encompassed a study of three issues: (1) to quantify any calculation errors included in the NPRM, (2) to analyze available data on current rates charged by Medicare providers for DSMT training, and (3) to analyze selected provider costs associated with this training function. In order to meet the anticipated date for regulation finalization, our review was limited to an analysis of existing payment data.

Based on our analysis:

- Medicare could make improper payments totaling $50 million between FY 2000 and FY 2003 due to simple calculation errors noted in the NPRM. Because Medicare deductibles and co-payments would also apply for these services, Medicare beneficiaries will also be adversely affected by the inflated payment rates in the amount of $12.5 million during the same period. We also found that the proposed rates include costs that should have been allocated to other programs; however, we did not have enough information to determine the related improper payments.

- When comparing HCFA's proposed group session rate ($32.62) to other group session rates in Washington State (involving 20 providers with an average session rate of $10.98) and one Maryland provider ($10.00), HCFA's rate appears to be substantially higher than that being charged in the marketplace.

- We found significant differences between HCFA's proposed rate (based on the ADA's data at two hospital-based providers - one on the east coast and one in the mid-west) and the actual cost of DSMT programs at two Maryland hospital-based providers. Because of the wide disparity between provider costs and the significant impact on the Medicare Trust Funds (based on a national estimate of almost 20 million hours of group session training being reimbursed by Medicare), we believe that additional cost analysis is needed before the payment rate is finalized.

RATE DEVELOPMENT PROCESS

In an effort to help establish payment rates for outpatient diabetes self-management training services, HCFA (1) attempted to gather Medicare historical payment data on diabetic training services, (2) reviewed a Washington State Diabetes Reimbursement Survey, and (3) requested that the ADA help establish payment rates by estimating the cost of furnishing an hourly training session.

The HCFA first attempted to gather Medicare historical payment data for DSMT services furnished prior to the enactment of the BBA of 1997. The HCFA found that reliable and consistent data did not exist because provider billing patterns varied greatly. These variations occurred because Medicare fiscal intermediaries had discretion on how providers could bill for DSMT services and allowed them to bill Medicare using many different billing codes. The HCFA also reviewed a Washington State Diabetes Reimbursement Survey compiled by diabetic educators within the Washington State area. However, HCFA did not use the data in this survey because it believed the universe in the survey was geographically limited.

The BBA of 1997 required DSMT services be paid under the MPFS in amounts established by the Secretary after consultation with appropriate organizations. Section 1848 of the Social Security Act required that payments under the MPFS be based on national uniform RVUs based on the resources used in furnishing a service. Under the MPFS, national RVUs were established for medical services comprising values for the work component, practice expenses, and malpractice expense. Thus, at HCFA's request, an advisory group of the ADA helped HCFA develop the proposed payment rates for diabetes outpatient self-management training services by estimating the resource cost of furnishing an hourly training session. Using the ADA estimated resource cost as a base, HCFA derived the proposed rates after making adjustments for certain cost categories. The HCFA accepted many of the ADA estimated costs for different cost categories without further examination and without determining if the costs were sufficiently supported.

American Diabetes Association Estimated Resource Costs

At HCFA's request, an advisory group of the ADA helped develop payment rates for Medicare's expanded coverage of DSMT services by estimating the resource cost of furnishing an hourly training session. The advisory group served on a volunteer basis and consisted of four diabetes practitioners from different diabetes programs around the country.

The advisory group derived an estimated cost of $76.67 per hour for both individual and group training sessions. In order to be consistent with the national RVUs under the MPFS, HCFA adjusted the advisory group amount to $55.41 and $32.62 for individual and group training sessions, respectively. Since the number of beneficiaries would vary, HCFA based its methodology on an assumption that there would be 10 beneficiaries attending a group session. Actual payments to an approved entity would be adjusted for geographic variation. An itemized listing of the various categories included in both the ADA and HCFA rates is provided in Appendix A.

The advisory group based its estimated resource costs primarily on two of the group members' operational budgets and expenses as they relate to their respective hospital-based DSMT programs; one on the east coast and one in the mid-west. The advisory group also used ADA and American Dietetic Association guidelines to help identify relevant cost categories and industry cost averages.

CALCULATION ERRORS

Based on our review of the February 11, 1999 NPRM for expanded coverage for outpatient diabetes self-management training services, it appeared that amounts for some of the costs categories within the proposed payment rates were incorrect due to calculation errors. These errors relate to the cost categories for billing insurance forms, follow-up telephone calls, and utilities. Although these calculation errors resulted in a minimal amount of excessive Medicare payments for 1999, they could result in improper Medicare program and beneficiary payments totaling $50 million and $12.5 million, respectively, for the 4-year period FY 2000 through FY 2003. The calculation errors were primarily due to HCFA's use of improper bases in its calculations when making adjustments to the ADA's estimated costs. Thus, some of the cost categories within the proposed rates were significantly inflated. The examples discussed below highlight the impact of the calculation errors. A comparison of the HCFA proposed rates and the rates adjusted for calculation errors we noted from our review is presented in Appendix A and our detail computations of the overpayments due to calculation errors is contained in Appendix B.

- **Billing Insurance Forms**

  The ADA estimated an amount for the costs associated with processing billing insurance forms and concluded 8 percent of the payment rate is reflective of this billing process. The HCFA agreed with allocating 8 percent of the Medicare payment rate to reflect these processing costs. In developing the Medicare rate, HCFA adjusted the ADA data by establishing a billing cycle period to reflect an average billing session of a 3-hour period. When HCFA adjusted the ADA amount for this billing insurance forms category, it erroneously used the ADA's estimated costs of $76.67 per session as a cost base, instead of using HCFA's adjusted hourly session payment rates of $55.41 (individual) and $32.62 (group) as a base. By using the ADA's estimated costs as a base, instead of using HCFA's adjusted bases, Medicare would pay $.72 and $1.36 more per hour for individual and group sessions, respectively. This could result in improper Medicare program and beneficiary payments totaling $24 million and $6 million, respectively, for the period FY 2000 through FY 2003.

  We compared the amounts for billing insurance forms covering the maximum recommended 10 hours of group session training. For three billing periods covering the 20 hours of group session training, the ADA estimated costs at $64.00 for billing insurance forms, while HCFA proposed paying $21.30. The OIG derived amount of $7.70 was based on HCFA's formula for allocating this cost. The per claim amount would be about $2.57 (based on three bills prepared and submitted). This is comparable to HCFA's estimate of $3.03 for resource cost of completing a hard copy of the HCFA-1500 billing form. The estimated resource cost for completing an electronic claim is $0.70.

- **Follow-up Telephone Calls**

  The ADA estimated an amount for follow-up phone calls to beneficiaries to cover the professional salary of the training personnel. The ADA rate was based on a 15 minute call for each beneficiary for every 1 hour session. The HCFA utilized the 15 minute call time but adjusted the rate to reflect a reduced calling pattern that included only 50 percent of the beneficiaries for each 1 hour session. When HCFA adjusted the ADA recommended amount for this category, it erroneously used the ADA's estimated professional salary hourly rate of $30.00 in its calculation, instead of using the HCFA developed adjusted professional salary hourly rate of $25.32. By using the ADA's estimated cost as a base, instead of using HCFA's adjusted bases, Medicare would pay $.59 more per hour for both its individual and group sessions. This could result in improper Medicare program and beneficiary payments totaling $12 million and $3 million, respectively, for the 4-year period of FY 2000 through FY 2003.

- **Utilities**

  The ADA estimated an amount for utilities by using a factor of 2 percent of total hourly costs. The HCFA agreed with using a factor of 2 percent of total hourly costs, but erroneously used the ADA's estimated hourly costs of $76.67 as a base, instead of using HCFA's adjusted hourly session payment rates of $55.41 (individual) and $32.62 (group) as a base. By using the ADA's estimated costs as a base, instead of using HCFA's adjusted bases, Medicare will pay $.34 and $.82 more per hour for individual and group sessions, respectively. This could result in improper Medicare program and beneficiary payments totaling $14 million and $3.5 million, respectively, for the 4-year period FY 2000 through FY 2003.

- **Shared Costs**

  The HCFA's proposed rates include costs that should be shared by other segments of a provider's total business operation. For example, the ADA advisory group that estimated the hourly resource costs of providing diabetes training improperly included the total cost for facility rent and computer software in its estimations. These costs should not have been fully allocated to the Medicare program as diabetes education program costs. Rather, these costs should have been allocated proportionately to a provider's diabetes education program segment and any other program segments (i.e., the provider's clinical program) that also use the facility and computer software. When HCFA adjusted the ADA's estimated resource costs, it did not take these improperly allocated costs into consideration and remove them from their calculations. We did not have enough information to quantify and determine the related improper payments, but we believe the allocation of 100 percent of the costs is incorrect and needs to be studied further.

CURRENT MARKETPLACE RATES

The second part of our review pertains to our analysis of the rates charged by providers for DSMT training. Although the information available was limited, it showed that the proposed rates were considerably higher than certain provider charges for DSMT services.

The BBA of 1997 provisions required that DSMT services be paid under the MPFS in amounts established by the Secretary after consultation with appropriate organizations. Under MPFS, rates are based on the resource costs (work component, practice expenses, and malpractice expense) of furnishing the service. Between 1994 and 1998, Medicare payment for diabetes education had been limited to services furnished in the hospital outpatient department and paid under Medicare Part B on a reasonable cost basis. The criteria established in the Medicare program clearly indicates that reasonable costs may vary from one institution to another because of scope of services, level of care, geographical location, and utilization. However, the costs among providers should not be substantially out of line with the costs of other providers. Also implicit in the intention of reasonableness is the expectation that the provider seeks to minimize its costs and that its actual costs do not exceed what a prudent and cost conscious buyer pays for a given item or service.

Based on data available on DSMT program rates, we believe that HCFA's proposed group session rate of $32.62 appears to be substantially higher than that charged in the marketplace. We reviewed the Washington State Diabetes Reimbursement Survey and visited two DSMT programs in Baltimore, Maryland to help gain an understanding of what was being charged in the marketplace for providing outpatient DSMT services.

Washington State Diabetes Reimbursement Survey

The Washington State Diabetes Reimbursement Survey was compiled by diabetic educators within the Washington State area. The survey examined reimbursement rates that had been paid by Medicare for more than 15 different payers within 20 different settings providing both group and individual sessions for diabetes education. The settings consisted of 17 hospitals, 1 clinic, 1 private provider, and 1 home health agency. The reimbursement rates reviewed were established by Medicare using reasonable cost reimbursement principles. Based on this survey, HCFA developed preliminary data indicating a Medicare average hourly payment rate for group and individual sessions of $10.98 and $30.03, respectively, which HCFA believed appropriate for implementing the BBA of 1997 requirements. However, HCFA subsequently decided not to use the data in this survey in its development of DSMT rates because it believed the universe in the survey was geographically limited.

Maryland Hospital-Based DSMT Programs

In addition to reviewing the Washington State Diabetes Reimbursement Survey, we visited two Maryland hospitals that had a DSMT program. The structure of both of the programs visited by the OIG appear to include the established criteria for curriculum content and faculty qualifications identified by HCFA in the NPRM. At one of the programs we visited, patients paid $10.00 per hour for group session training, which was significantly lower than HCFA's proposed amount of $32.62 per hour for group session training. The second provider did **NOT** charge for its DSMT program.

ACTUAL PROVIDER COSTS

The third part of our review pertained to our analysis of actual costs providers incurred for DSMT services. Even though our data was limited, based on our analysis there was a wide disparity between certain cost elements of the proposed rates and the actual costs that we found at certain providers. These disparities pointed out that further study is needed before the rates are finalized.

Site Visits to Hospital-Based Programs

To help gain an understanding of the actual costs incurred in providing DSMT programs, we reviewed the records of two providers with DSMT programs in Baltimore, Maryland. During our limited review at these 2 providers, we examined 4 of the 19 cost categories within HCFA's proposed payment rates and found significant differences between HCFA's proposed rate and the actual cost of the outpatient DSMT programs at these providers. The four cost categories examined included counseling materials, computer software, reports to referral source, and follow-up phone calls. The HCFA proposed hourly cost of these four cost categories totaled $14.03 and represented 43 percent of the total HCFA proposed hourly costs of $32.62. For the four cost categories examined at the two providers, we found that the average actual cost only totaled $1.76, a $12.27 difference from HCFA's respective proposed costs. A line by line comparison of these costs is included as Appendix C.

Applying these significant payment differences to all anticipated group session training hours indicated the Medicare program and its beneficiaries could pay substantially more for this training than warranted.

When comparing amounts for the maximum recommended 10 hours of group session training, it was apparent that HCFA's recommended amounts should be adjusted. For example, at the two providers we visited, reports to referral sources generally consisted of a two to six page checklist informing the referring physician of the types of training the patient received. The actual costs of providing the reports to the referring physician was $0.90. However, HCFA proposed paying $43.20 for reports to referral sources.

We acknowledge that our audit work was limited. However, our work and the results of the Washington State Diabetes Reimbursement Survey provided anecdotal information which indicated the present proposed training reimbursement rates may be substantially higher than warranted.

CONCLUSIONS AND RECOMMENDATIONS

We acknowledge that HCFA attempted to develop reasonable payment rates for outpatient diabetes self-management training services. However, we are concerned that the proposed payment rates for both individual and group sessions are inflated and based on costs that cannot be sufficiently supported. In addition to the inflated proposed rates due to calculation errors, we found several instances where HCFA's group session rate was substantially higher than what was being charged in the marketplace.

Available data from the Washington State Diabetes Reimbursement Survey, encompassing 20 providers from various settings, was not used by HCFA in developing DSMT rates because it was considered geographically limited. The HCFA, instead, used the ADA data which was primarily based on only two providers in establishing the DSMT rates. Data we gathered from two Maryland providers also show provider costs for DSMT programs that are more reflective of the costs at the Washington State providers. We are concerned that the proposed payment rates will continue to be excessive if HCFA uses them as a baseline when incorporating DSMT services into the MPFS.

We, therefore, recommend that HCFA further review the rates contained in the NPRM. At a minimum, the rates should be adjusted downward to reflect the correction of calculation errors found in our review. We would be pleased to provide additional details about our review for your use in adjusting the payment rates. We would also be willing to work with HCFA to perform any additional studies deemed appropriate to obtain better data on DSMT services so that accurate base year costs could be developed.

HCFA'S COMMENTS

The HCFA did not concur with our recommendation that the payment rates should be adjusted downward to reflect the correction of calculation errors found in our review. However, HCFA did agree that the payment rates should be refined as additional experience and knowledge is gained about DSMT services. The HCFA plans on refining the payment rates by incorporating them into the refinement process used for other Medicare services payable under the Medicare physician fee schedule. The HCFA also disagreed that Medicare would achieve savings by making the OIG recommended revisions due to the budget neutrality provision of the physician fee schedule. The full text of HCFA's response is included with this report as Appendix D.

OIG RESPONSE

One purpose of the NPRM was to set forth the proposed payment amounts for the DSMT program under the physician fee schedule (based on the RVU system). The value of the RVU should be based on the resources needed to furnish the service. We still believe that the rate assigned by HCFA is excessive based on our analysis. We believe that the NPRM comment period allows HCFA the discretion to make changes and the most opportune time to refine the payment rates for DSMT services is before the rates are finalized. The budget neutral provision allows HCFA the latitude to make an adjustment for DSMT services under section 1848(c)(2)(B)(ii) as either a new procedure and/or as new data on the relative value components. In addition, the annual recommended adjustment is less than the $20 million threshold. Also, the timeliness of making the refinements is critical to saving the Medicare program and its beneficiaries millions of dollars. As such, we continue to recommend that HCFA further review the payment rates contained in the NPRM. At a minimum, the rates should be adjusted downward to reflect the elimination of calculation errors found in our review. We have also modified our report to address HCFA's technical comments.

We do, however, acknowledge that HCFA has raised some good points in their comments. We plan, therefore, to expand our work in this area into a national study of the training services being rendered. We plan to have the results of this review completed by late summer of 2000. We suggest that if HCFA has to finalize the proposed rule on this issue before our work is completed, then HCFA may want to acknowledge in the final rule that the OIG is performing some additional work and the rates may be modified at a later date.

HCFA'S TECHNICAL COMMENTS and OIG RESPONSE

HCFA Comment: The HCFA requested additional information on the two providers that were able to furnish DSMT services for $10 per hour.

OIG Response: For the comparison in the hourly rate for DSMT services, we based our conclusions on HCFA's own analysis of Medicare reimbursement under the State of Washington Reimbursement Survey which included 20 providers. We also examined two providers in Maryland, however, only one provider had an hourly rate which was $10. The second provider did **NOT** charge for their DSMT program. The structure of both of the programs visited by the OIG included the established criteria for curriculum content and faculty qualifications identified by HCFA in the NPRM.

HCFA Comment: The HCFA questioned how a provider could cover its billing costs for the $0.77 hourly rate used in our calculations.

OIG Response: The amount calculated for billing was based on HCFA's methodology in computing its own billing rate. The only difference was HCFA used an incorrect base amount as its starting point. We have further analyzed the adjusted rate and found that it is

comparable to the cost for physician and suppliers for preparing a hard copy of the HCFA-1500 and considerably more in preparing an electronic claim. We have modified the report to reflect these various costs.

HCFA Comment: The HCFA also believed that its estimate of $4.32 per hour for the cost of reports to referral sources will go further in ensuring the quality of information sharing than the $0.09 hourly rate used in our calculations.

OIG Response: The amount for the cost of referral reports was based on our site visits to two providers. The purpose of the comparisons to the actual costs of providers was to demonstrate that the actual costs for comparable programs was significantly lower than the costs estimated for the proposed rates. The DSMT rate was based on an ADA survey of costs at only two providers. This analysis demonstrates that if the proposed rates were based on two providers (ADA data), and similar costs at two different providers is diametrically opposed, then additional analysis needs to be done before the rates are finalized.

HCFA Comment: The HCFA believed that the $0.84 amount for general physician oversight of the DSMT program was reasonable and should be included in the rate.

OIG Response: We concur with HCFA and have made the necessary changes to the report and our calculations to reflect retention of this cost.

APPENDICES

Comparison of Rates for Outpatient Diabetes Self-Management Training

Service Description	ADA Estimated Costs	HCFA Proposed Group Rate	HCFA Proposed Individual Rate	OIG Adjusted Group Rate[3]	OIG Adjusted Individual Rate[3]
DIRECT COSTS					
Professional Salary Per Hour (RN or RD)	$30.72	$ 2.53	$ 25.32	$ 2.53	$ 25.32
Physician Oversight	$ 6.00	$ 0.84	$ 0.84	$ 0.84	$ 0.84
Counseling Materials	$ 5.00	$ 5.00	$ 5.00	$ 5.00	$ 5.00
Computer Software	$ 0.96	$ 0.96	$ 0.96	$ 0.96	$ 0.96
Calculators, Scales, Gloves	$ 0.25	$ 0.25	$ 0.25	$ 0.25	$ 0.25
Reference Materials	$ 0.25	$ 0.25	$ 0.25	$ 0.25	$ 0.25
Billing Insurance Forms	$ 6.40	$ 2.13	$ 2.13	$ 0.80	$ 1.43
Record Maintenance	$ 3.00	$ 3.00	$ 3.00	$ 3.00	$ 3.00
Scheduling Patients	$ 2.00	$ 2.15	$ 2.15	$ 2.15	$ 2.15
Reports to Referral Source	$ 4.32	$ 4.32	$ 4.32	$ 4.32	$ 4.32
No Shows	$ 3.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00
Phone Calls	$ 7.50	$ 3.75	$ 3.75	$ 3.16	$ 3.16
TOTAL DIRECT	$69.40	$25.18	$47.97	$23.26	$46.68
INDIRECT COSTS					
Rent	$ 2.25	$ 2.25	$ 2.25	$ 2.25	$ 2.25
Utilities	$ 1.40	$ 1.40	$ 1.40	$ 0.60	$ 1.08
Office Supplies & Equipment	$ 1.73	$ 1.73	$ 1.73	$ 1.73	$ 1.73
Telephone	$ 0.72	$ 0.72	$ 0.72	$ 0.72	$ 0.72
Continuing Education	$ 0.72	$ 0.72	$ 0.72	$ 0.72	$ 0.72
Accounting	$ 0.25	$ 0.25	$ 0.25	$ 0.25	$ 0.25
TOTAL INDIRECT	$ 7.07	$ 7.07	$ 7.07	$ 6.27	$ 6.75
Malpractice/Legal Fees	$ 0.20	$ 0.37	$ 0.37	$ 0.37	$ 0.37
TOTAL COSTS	$76.67	$32.62	$55.41	$29.90	$53.80

[3]OIG adjustments compensate for calculation errors.

Schedule of Improper Payments — Calculation Errors
Summary of Group and Individual Combined Medicare
Improper Payments Impact

Improper Payments	2000	2001	2002	2003	2000 - 2003
Medicare Program					
Billing Insurance Forms	$9,648,204	$7,916,475	$4,453,018	$1,979,119	$23,996,815
Follow-up Telephone Calls	$4,830,807	$3,963,739	$2,229,603	$990,935	$12,015,084
Utilities	$5,604,280	$4,598,384	$2,586,591	$1,149,596	$13,938,851
Total	$20,083,291	$16,478,598	$9,269,212	$4,119,649	$49,950,750
Beneficiary					
Billing Insurance Forms	$2,412,051	$1,979,119	$1,113,254	$494,780	$5,999,204
Follow-up Telephone Calls	$1,207,702	$990,935	$557,401	$247,734	$3,003,771
Utilities	$1,401,070	$1,149,596	$646,648	$287,399	$3,484,713
Total	$5,020,823	$4,119,649	$2,317,303	$1,029,912	$12,487,687

RECONCILIATION TO B-2 AND B-3
2000

Medicare Total	$20,083,291	Group (B-2)	$21,137,952
Beneficiary Total	5,020,823	Individual (B-3)	3,966,161
Grand Total[4]	$25,104,114	Grand Total	$25,104,113

[4]Appendix B-2 and B-3 provide details on the improper payments associated with group session rates only (See B-2) and with individual session rates only (See B-3). Totals from B-2 and B-3, by year, are not exact matches to the summary schedule above due to roundings resulting from various calculations.

Schedule of Improper Payments - Calculation Errors
For Group Session Only[5]

	2000	2001	2002	2003	2000 - 2003
Group Expenditures	$253,500,000	$208,000,000	$117,000,000	$52,000,000	$630,500,000
Group Hours	7,771,306	6,376,456	3,586,757	1,594,114	19,328,633
Payment Differences					
Billing Insurance Forms	$1.33	$1.33	$1.33	$1.33	$1.33
Follow-up Telephone Calls	$0.59	$0.59	$0.59	$0.59	$0.59
Utilities	$0.80	$0.80	$0.80	$0.80	$0.80
Total Payment Differences	$2.72	$2.72	$2.72	$2.72	$2.72
Improper Payments					
Billing Insurance Forms	$10,335,837	$8,480,686	$4,770,387	$2,120,172	$25,707,082
Follow-up Telephone Calls	$4,585,071	$3,762,109	$2,116,186	$940,527	$11,403,893
Utilities	$6,217,045	$5,101,165	$2,869,406	$1,275,291	$15,462,907
Total Improper Payments	$21,137,953	$17,343,960	$9,755,979	$4,335,990	$52,573,882

[5]Total improper payments for each year reflects both the Medicare program payments and the beneficiaries payments.

Schedule of Improper Payments - Calculation Errors and Regulation Conflict For Individual Session Only[6]

	2000	2001	2002	2003	2000 - 2003
Individual Expenditures	$136,500,000	$112,000,000	$63,000,000	$28,000,000	$339,500,000
Individual Hours	2,463,454	2,021,296	1,136,979	505,324	6,127,053
Payment Differences					
Billing Insurance Forms	$0.70	$0.70	$0.70	$0.70	$0.70
Follow-up Telephone Calls	$0.59	$0.59	$0.59	$0.59	$0.59
Utilities	$0.32	$0.32	$0.32	$0.32	$0.32
Total Payment Differences	$1.61	$1.61	$1.61	$1.61	$1.61
Improper Payments					
Billing Insurance Forms	$1,724,418	$1,414,907	$795,885	$353,727	$4,288,937
Follow-up Telephone Calls	$1,453,438	$1,192,565	$670,818	$298,141	$3,614,961
Utilities	$788,305	$646,815	$363,833	$161,704	$1,960,657
Total Improper Payments	$3,966,161	$3,254,287	$1,830,536	$813,572	$9,864,555

[6]Total improper payments for each reflects both the Medicare program payments and the beneficiaries payments.

Appendix C

Comparison of Estimated, Proposed and Actual Costs for Outpatient Diabetes Self-Management Training

Service Description	ADA Estimated Costs	HCFA Proposed Rate	Hospital A Costs[7]	Hospital B Costs[7]	Average Hospital Costs[8]	Difference Proposed vs. Actual Costs
Direct Costs		**(A)**			**(B)**	**(C)[9]**
Counseling Materials	$ 5.00	$ 5.00	$ 1.19	$ 1.67	$ 1.43	$ 3.57
Computer Software	$ 0.96	$ 0.96	$ 0.03	$ 0.03	$ 0.03	$ 0.93
Reports to Referral Source	$ 4.32	$ 4.32	$ 0.07	$ 0.10	$ 0.09	$ 4.23
Phone Calls	$ 7.50	$ 3.75	$ 0.24	$ 0.18	$ 0.21	$ 3.54
Total	**$17.78**	**$14.03**	**$ 1.53**	**$ 1.98**	**$ 1.76**	**$12.27**

[7]These were the two locations reviewed by OIG.

[8]Only relates to the two hospitals reviewed.

[9]Column (C) = Column (A) minus Column (B)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Deputy Administrator
Washington, D.C. 20201

DATE: OCT 27 '99

TO: June Gibbs Brown
Inspector General

FROM: Michael M. Hash
Deputy Administrator

SUBJECT: Office of the Inspector General (OIG) Draft Report: "Medicare Program; Expanded Coverage of Outpatient Diabetes Self-Management Training Services," (A-14-99-00207)

Thank you for the opportunity to review and comment on the above-referenced report. The report assesses the reasonableness of the individual and group session payment rates proposed by the Health Care Financing Administration (HCFA) for outpatient diabetes self-management training (DSMT) services. The Balanced Budget Act of 1997 expanded Medicare coverage for outpatient DSMT to include services furnished by non-hospital-based programs.

The report indicates that the proposed individual and group session payment rates are inflated because they include calculation errors and costs that directly conflict with the governing regulation. The report recommends that the rates contained in the proposed rule be adjusted downward to better reflect the hourly costs in the marketplace.

HCFA is committed to paying providers fairly so that Medicare beneficiaries have access to the training they need to better control their diabetes. Initial payments for DSMT services are based on resource-based relative value units that reflect work, practice expenses, and malpractice expense. As we gain additional experience and knowledge about individual and group session services, the relative values for this and other services will be refined. This is consistent with how we establish payments for new services under the physician fee schedule. Our detailed comments are attached.

Attachment

Comments of the Health Care Financing Administration on Office of Inspector General Draft Report: "Medicare Program; Expanded Coverage of Outpatient Diabetes Self-Management Training Services," (A-14-99-00207)

OIG Recommendation

HCFA should further review the rates contained in the Notice of Proposed Rule Making (NPRM) and consider adjusting them downward to better reflect actual hourly costs in place in the marketplace. At a minimum, the rates should be adjusted downward to reflect the correction of calculation errors found in our review.

HCFA Response

We do not concur. We do not agree that calculation errors were made in developing payment rates. Initial payments for DSMT services are based on resource-based relative value units (RB-RVUs). The relative value units reflect work, practice expense, and malpractice expense. They were established in a manner consistent with how we establish payments for other new services under the physician fee schedule. However, we agree that the initial payment rates established for this service should be refined as we gain additional experience and knowledge about these services. We plan to do this as part of our continuing refinement of the relative values for this service and other services paid under the physician fee schedule.

We disagree with the OIG's findings that Medicare would achieve savings by making the revisions suggested. We would make any revisions to the RB-RVUs for these services, or any of the other 7,000 services covered under the physician fee schedule, in a budget neutral manner as required by statute (section 1842(c)(2)(B)(ii) of the Social Security Act).

Technical Comments:

1. The report indicates that at two providers reviewed, reported charges for their services were far lower than the group rates established by Medicare (e.g., about $10 per group session for the two providers reviewed compared to the Medicare group rate of $32.62 per hourly session). This is cited as evidence that the Medicare rate is too high. We seriously question that the quality of services we believe are necessary and that were developed in consultation with the American Diabetes Association (ADA) can be provided at a rate of $10 per hour per group member. It would be helpful if the OIG could provide more information about the

services being provided by these two providers. Perhaps the services being provided in these two cases are not comparable with our expectations of a quality program, or perhaps these services are being provided essentially for free as part of these providers' marketing or community outreach.

2. The report further indicates that we made various calculation errors. As an example, the report explains that we should have allocated $0.77 per group session per attendee to cover the provider's billing costs rather than the $2.13 amount used. We seriously question how a provider could cover its billing costs for $0.77 per beneficiary per session. Billing costs include many administrative activities as part of the billing process, including following up to record payment, co-pays, etc. As another example, the report indicates that we should have allocated $0.09 per session to cover the costs of reports to referral sources, rather than the $4.32 amount that was used in our estimates. We believe that for a quality program, there must be information sharing between the referring physician and the education provider. Such information sharing is critical if the full benefit of the training services is to be realized. We believe that $4.32 will go farther in ensuring that this information-sharing will take place rather than the $0.09 proposed.

3. Finally, the report indicates that the payment rate was established in a way that conflicts with our regulations. Specifically, it suggested that we should not have allocated $0.84 per group session to cover the costs of general physician supervision and oversight of these programs. It is also suggested that this approach conflicts with our regulations because we indicate in the regulations that diabetic self-education training need not be performed by a physician. We agree that this service would not typically be performed by a physician. However, the ADA recommended, and we believe it is reasonable, for there to be general professional (e.g. a physician, nurse practitioner) oversight or management of the program.