



## Memorandum

JUL 29 1998

Date June Gibbs Brown  
From Inspector General *June G. Brown*

Subject Review of the Health Care Financing Administration's Development of a Prospective Payment System for Skilled Nursing Facilities (A-14-98-00350)

TO Nancy-Ann Mm DeParle  
Administrator  
Health Care Financing Administration

Attached is our final report entitled, "Review of the Health Care Financing Administration's Development of a Prospective Payment System for Skilled Nursing Facilities."

The purpose of this report is to provide you with our concerns on the Health Care Financing Administration's (HCFA) development of a prospective payment system for skilled nursing facilities (PPS/SNF). While we acknowledge that HCFA has attempted to construct reasonable PPS/SNF rates, we are concerned that the methodology used will cause those rates to be inflated. We do not believe that HCFA's rate methodology adequately adjusts for medically unnecessary care and/or the amount of improper payments that have been made to skilled nursing facilities (SNF). If these incorrect payments are not eliminated from the base period costs, an unwarranted financial windfall will be realized by the SNF providers. We also note that HCFA, through a recent rule, issued salary equivalency guidelines for use in paying therapy costs (which includes SNF services) which show that significant savings will be realized over a 3-year period. Although we have not been able to determine the effect the new rule would have in the base period costs, we do not see where in the interim rule an adjustment for these new salary equivalency guidelines was considered in establishing the base year costs.

We are recommending that HCFA determine the costs of such unnecessary care or excessive salary costs for therapy services and eliminate them from PPS/SNF rates. Recognizing that HCFA faced tight time frames for issuing the interim final rule, we recommend that these proposed rates be further reviewed and adjusted downward to reflect the amount of improper payments in the base year costs. We believe the results of our audits of HCFA's financial statements for Fiscal Year (FY) 1996 and FY 1997 and other Office of Inspector General studies can be of help to HCFA in arriving at an adjustment percentage. The FY 1996 audit results showed over \$23 billion in improper Medicare benefits payments had been made. Approximately \$2.4 billion of this total reflect SNF payments. Of the estimated \$20.3 billion of incorrect payments in FY 1997, \$629 million related to SNF payments. Although these values of SNF improper payments should not be used independently as a bench-marking number, we believe they do reflect the fact that significant improper SNF payments have been made and are a part of the base period costs.

Page 2 - Nancy-Ann Min DeParle

We would be pleased to provide you additional details about our financial statement audit results for your use in adjusting the PPS/SNF values included in the interim rule. We would also be glad to work with HCFA to perform any additional studies you deem appropriate.

In response to our draft report, HCFA agreed that it and the OIG will examine base year cost data and eliminate inappropriate costs by reducing future rates. The HCFA's complete response is included as Attachment IV.

Please advise us within 60 days on actions taken or planned on our recommendation. If you have any questions, please call me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits at (4 IO) 786-7 104.

To facilitate identification, please refer to Common Identification Number A-14-98-00350 in all correspondence relating to this report.

Attachment

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**REVIEW OF THE  
HEALTH CARE FINANCING ADMINISTRATION'S  
DEVELOPMENT OF A  
PROSPECTIVE PAYMENT SYSTEM  
FOR  
SKILLED NURSING FACILITIES**



**JUNE GIBBS BROWN  
Inspector General**

**JULY 1998  
A-14-98-00350**

**Memorandum**

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June Gibbs Brown

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Inspector General *June Gibbs Brown*

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Review of the Health Care Financing Administration's Development of a Prospective Payment System for Skilled Nursing Facilities (A-14-98-00350)

To

Nancy-Ann Min DeParle  
Administrator  
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This final report provides you with our concerns on the Health Care Financing Administration's (HCFA) development of a prospective payment system for skilled nursing facilities (PPS/SNF). While we acknowledge that HCFA has attempted to construct reasonable PPS/SNF rates, we are concerned that the methodology used will cause those rates to be inflated. We do not believe that HCFA's rate methodology adequately adjusts for medically unnecessary care and/or the amount of improper payments that have been made to skilled nursing facilities (SNFs). If these incorrect payments are not eliminated from the base period costs, SNF providers will be overpaid. We also note that HCFA, through a recent rule, issued salary equivalency guidelines for use in paying therapy costs (which includes SNF services) which show that significant savings will be realized over a 3-year period. Although we have not been able to determine the effect this new rule would have in the base period costs, we do not see where in the interim rule an adjustment for these new salary equivalency guidelines was considered in establishing the base year costs.

We are recommending that HCFA determine the costs of such unnecessary care or excessive salary costs for therapy services and eliminate them from PPS/SNF rates. Recognizing that HCFA faced tight timeframes for issuing the interim final rule, we recommend that these proposed rates be further reviewed and adjusted downward to reflect the amount of improper payments in the base year costs. We believe the results of our audits of HCFA's financial statements for Fiscal Year (FY) 1996 and FY 1997 and other Office of Inspector General (OIG) studies can be of help to HCFA in arriving at an adjustment percentage. The FY 1996 audit results showed over \$23 billion in improper Medicare benefit payments had been made. Approximately \$2.4 billion of this total reflect SNF payments. Of the estimated \$20.3 billion of incorrect payments in FY 1997, \$629 million related to SNF payments. Although these values of SNF improper payments should not be used independently as a bench-marking number, we believe they do reflect the fact improper significant SNF payments have been made and are a part of the base period costs. We would be pleased to provide you additional details about our financial statement audit results. We would also be glad to work with HCFA to perform additional studies to quantify incorrect base year costs.

In response to our draft report, the HCFA agreed that it and the OIG will examine base year cost data and eliminate inappropriate costs by reducing future rates. The HCFA's complete response is included as Attachment IV to this report.

**CURRENT SYSTEM FOR PAYMENT OF SKILLED NURSING  
FACILITY SERVICES UNDER MEDICARE PART A**

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Under the present payment system, Medicare SNF services are paid according to a retrospective, reasonable cost-based system. The SNFs receive payment for three major cost categories: routine costs, ancillary costs, and capital-related costs according to the Medicare payment principles set forth in section 1861 of the Social Security Act (the Act) and part 413 of the CFR.

In general, routine costs are the costs of those services included by the provider in a daily service charge. Included in routine service costs are the regular room dietary, nursing services, minor medical supplies, medical social services, psychiatric social services, and the use of certain facilities and equipment for which a separate charge is not made. Ancillary costs are those costs for specialized services, such as therapy, drugs, and laboratory services, that are directly identifiable to individual patients. Capital-related costs include the costs of land, building, equipment, and the interest incurred in financing the acquisition of such items.

Under Medicare rules, the reasonable costs of ancillary services and capital-related expenses are paid in full. Routine operating costs are paid on a reasonable cost basis as well; however, they are also subject to per diem limits. Sections 1861(v)(I) and 1888 of the Act authorize the Secretary to set limits on the allowable routine costs incurred by a SNF.

In addition, section 1888(d) of the Act gives low Medicare volume SNFs the option of receiving a single prospectively determined payment rate for routine operating and capital-related costs in lieu of the normal reasonable cost reimbursement method. A SNF may elect this payment method only if it had fewer than 1,500 Medicare covered inpatient days in its immediately preceding cost reporting period. A SNF's prospective payment rate, excluding capital-related costs, cannot exceed its routine service cost limits. Under this payment method, ancillary costs are still a pass-through cost.

**BALANCED BUDGET ACT OF 1997 REQUIREMENT FOR A  
PROSPECTIVE PAYMENT SYSTEM FOR SKILLED NURSING FACILITIES**

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Section 4432(a) of the Balanced Budget Act of 1997 (BBA 1997) (Public Law 105-33), enacted on August 5, 1997, amended section 1888 of the Act by adding subsection (e). This subsection requires implementation of a Medicare PPS/SNF for cost reporting periods beginning on or after July 1, 1998. Under the PPS, SNFs will no longer be paid in

accordance with the present reasonable cost-based system or through low-volume prospectively determined rates but rather through a PPS applicable to all covered SNF services. These payment rates will cover all costs of furnishing covered skilled nursing services (that is, routine, ancillary, and capital-related costs) other than costs associated with operating approved educational activities. Covered SNF services include post-hospital SNF services for which benefits are provided under Part A (the hospital insurance program) and all items and services for which, prior to July 1, 1998, payment had been made under Part B (the supplementary medical insurance program) but furnished to SNF residents during a Part A covered stay.

Section 1888(e)(4) of the Act provides the basis for the establishment of the per diem Federal payment rates applied under the PPS. It sets forth the formula for establishing the rates, as well as the data on which they are based. In addition, this section prescribes adjustments to such rates based on geographic variation and case mix and the methodology for updating the rate in future years.

Section 1888(e)(2) applies to most providers during the transition phase covering the first three cost reporting periods under the PPS. During this transition, SNFs will receive a payment rate comprised of a blend between the Federal rate and a facility-specific rate based on historical costs. For the first cost reporting period, the PPS/SNF rate will be comprised of 75 percent of the facility-specific rate and 25 percent of the Federal rate. For the second cost reporting period, the PPS/SNF rate will be 50 percent facility-specific rate and 50 percent Federal rate. For the third cost reporting period, it will be 25 percent facility-specific rate and 75 percent Federal rate. For all subsequent cost reporting periods after the transition, the PPS/SNF rate will be 100 percent of the Federal rate. Section 1888(e)(3) provides the basis for computing the facility-specific rates.

Resident-specific per diem Federal rates are to provide payment for all costs of services furnished to a Medicare resident of a SNF. The Federal rates, which are based on mean SNF costs in a base year (that is, cost reporting periods beginning in FY 1995), are adjusted using the hospital wage index to account for geographic differences in wage levels and updated for inflation using the SNF market basket to the first effective period of the system (15-month period beginning July 18, 1998, and ending September 30, 1999). Residents are classified into 1 of 44 mutually exclusive case mix groups using the data from the minimum data set. The Federal rates are adjusted using case mix indices to reflect the relative resources required among the 44 groups.

#### **SCOPE**

The objective of our review was to assess the reasonableness of the PPS/SNF rates being developed by HCFA. To accomplish our objective, we analyzed our prior audit work of 21 SNFs in 5 States, our audits of HCFA's FY 1996 and FY 1997 financial statements, our review of physical and occupational therapy services at 6 SNFs in California, our reviews of

Medicare payments for incontinence supplies, wound care, and enteral nutrition, and the General Accounting Office's (GAO) reports on SNF therapy services, as well as HCFA's interim final rule on PPS/SNF. Our limited-scope review was made in accordance with generally accepted government auditing standards. The work was performed during January through April 1998 at HCFA's central office.

### **FINANCIAL STATEMENT AUDIT RESULTS**

In our audits of HCFA's FY 1996 and FY 1997 financial statements, we used a multistage stratified statistical sample design. The first stage consisted of a random selection of 12 contractor quarters during each FY. The second stage consisted of a random sample of 50 beneficiaries from each contractor quarter stratified into 4 strata by total amount of payments for services. For each year, this resulted in a random sample of 600 beneficiaries nationwide. We made detailed medical and audit reviews of all claims processed for payment for each selected beneficiary during the 3-month period.

Our review showed that the Medicare program is inherently vulnerable to incorrect provider billing practices. We estimated that improper Medicare benefit payments made during FY 1996 totaled \$23.2 billion, or about 14 percent of the \$168.6 billion in processed fee-for-service payments reported by HCFA. The estimated range of the improper payments at the 95 percent confidence level is \$17.8 billion to \$28.6 billion, or about 11 percent to 17 percent. The results of our financial statement audit indicated that about 10.45 percent of the total incorrect payments were related to SNF services. Included as Attachment I is an excerpt from the audit detailing the overall and SNF-specific improper payments during FY 1996.

Similar results were noted in FY 1997. In that year, we estimated that net overpayments totaled about \$20.3 billion or about 11 percent of total Medicare fee-for-service payments. The estimated range of overpayments during FY 1997 at the 95 percent confidence level is \$12.1 billion to \$28.4 billion, or about 7 percent to 16 percent. Our results indicate that about 3.1 percent of the total incorrect payments were related to SNF services. Included as Attachment II is an excerpt from the audit showing overall and SNF-specific improper payments during FY 1997.

Here are some examples of SNF problems detected during our audit field work:

- Medicare reimbursed a hospital-based SNF \$9,365 for a **25-day** skilled nursing stay by a 79-year-old patient. The contractor's medical review staff determined that the patient's medical records did not support the provision of skilled nursing care. Medical records documented that the patient received only maintenance-level

(nonskilled) nursing home care. Medicare does not reimburse non-skilled services, such as assisting a patient with daily living or meeting personal needs, that could be safely provided by individuals without professional skills or training.

- A SNF received \$15,362 for 61 days of care, including room/board, respiratory therapy services, and other miscellaneous supplies. Based on the medical review, this claim was denied because the medical records did not document a chronic illness or condition necessitating a skilled level of care. The medical reviewer indicated that the patient was stable and that the provider should have known that skilled services were not necessary. Accordingly, the reviewer disallowed the entire payment.
- Certain SNFs claimed unallowable services by billing Medicare separately for various routine services already included in their flat-rate reimbursement.

#### PROVIDER-SPECIFIC AUDITS

The OIG, along with HCFA personnel, performed a series of audits of 21 individual SNF providers in Florida, New York, Illinois, Texas, and California. The SNFs were judgmentally selected for audit based on their aberrant billings, including high therapy costs, high average length of stay by residents, high cost per stay, and high cost per day. To determine if Medicare had paid for medically unnecessary or over utilized services, we reviewed the allowability of SNF-reported charges for the following services:

- room and board
- physical therapy
- occupational therapy
- respiratory therapy
- speech therapy
- telemetry/EKG
- radiology
- drugs
- laboratory services

These reviews were conducted by teams comprised of two nurse consultants (one from HCFA and one from the State agency for licensing and certification) and one or two OIG auditors. The nurses identified services that were not reasonable or medically necessary, not supported in the medical records, or not allowable. The auditors then quantified the charges associated with the services questioned by the nurses and any other services that were not in compliance with Federal regulations.

The reviews showed that the 21 SNFs had overbilled the Medicare program approximately \$3.4 million for ancillary services that did not meet Medicare reimbursement guidelines. The

reports for these assignments were released to the applicable intermediaries shortly after the completion of the reviews so that the intermediaries could collect the identified overpayments. Details on these audits are shown in Attachment III.

### **INSPECTIONS OF PART B PAYMENTS FOR NURSING HOME SERVICES**

A series of inspections of Part B payments for nursing home services showed that Medicare was paying for unnecessary supplies in wound care, incontinence care, and **enteral** nutrition. We found that questionable payments for wound care supplies accounted for as much as two-thirds of the \$98 million in Medicare allowances from June 1994 through February 1995. In our sample, less than 40 percent of beneficiaries resided in nursing homes, but these beneficiaries received over 70 percent of wound care benefits. We found that questionable billing practices may have accounted for almost half of incontinence allowances in 1993. Through aggressive efforts by HCFA, Durable Medical Equipment Regional Carriers, and the OIG to prevent questionable allowances for incontinence supplies, abusive billings have all but disappeared, but outlays reported for earlier years still reflect erroneous payments. We also found that Medicare reimbursement for **enteral** nutrients substantially exceeds purchase prices commonly available to nursing homes through volume purchasing and other contractual relationships.

### **REVIEW OF PHYSICAL AND OCCUPATIONAL THERAPY SERVICES AT SIX SKILLED NURSING FACILITIES IN CALIFORNIA**

We issued an early alert on our recently completed medical review of physical and occupational therapy services for a probe sample of six SNFs in California. The purpose of the review was to determine if the level of medically unnecessary services was sufficient to warrant a national inspection. In collaboration with a medical review contractor, we conducted on-site reviews of medical records for a random sample of Medicare beneficiaries for whom the intermediaries processed claims during August 1997. The reviewer assessed a total of 80 records to determine the extent to which patients received physical and/or occupational therapy in accordance with Medicare guidelines.

Our preliminary findings show that medically unnecessary physical and occupational therapy services at sampled facilities ranged from less than 4 percent to more than 80 percent. More than one-quarter of therapy services were medically unnecessary at five of the six SNFs. The remaining facility, which had less than 4 percent medically unnecessary services, had recently been under prepayment review by its fiscal intermediary. For most of the unnecessary therapies, skilled therapy services were provided although the medical records did not document the need for the services based on Medicare guidelines. In other cases, the patients' files were missing, failed to contain physician orders, or did not include

any evidence that therapy had been provided. The rates of medically unnecessary services were slightly higher for occupational therapy than for physical therapy.

The following types of problems were found: skilled services were frequently provided when nonskilled services would have been more appropriate; therapists sometimes ignored the beneficiaries prior level of function and set unrealistic goals; the frequency of therapy was sometimes excessive; the time billed for therapy exceeded the actual time that services were provided; and recurring hospitalization may have triggered unnecessary therapy services.

As the above preliminary results indicate, our probe sample findings detail some significant concerns about the medical necessity of therapy services provided to SNF patients.

SALARY EQUIVALENCY GUIDELINES  
ON MEDICARE PAYMENTS FOR THERAPY SERVICES

The issue of overcharges for therapy services delivered to nursing home patients has also been reported by GAO.' The GAO reported that Medicare had paid substantially more than market rates for some services, which not only increased Medicare costs, but could also encourage providers to supply excessive services. According to GAO, SNFs and outpatient rehabilitation therapy companies continued to charge excessively high rates for therapy services, particularly occupational and speech therapy, when services were provided under arrangement. To correct this problem, GAO recommended that HCFA implement salary equivalency guidelines for occupational and speech therapists. The GAO reported that given HCFA's experience with payments for physical therapy, the new guidelines should help moderate payment growth rates.

Section 1861(v)(5) of the Act requires the Secretary to determine the reasonable cost of services furnished to Medicare beneficiaries "under an arrangement" with a provider of services by therapists or other health-related personnel. The HCFA pays the provider directly for these services, rather than paying the therapist or supplying organization. Section 1861(v)(5) of the Act also specifies that the reasonable costs for these services may not exceed an amount equal to the salary that would reasonably have been paid for the services. Effective April 1, 1998, HCFA revised the salary equivalency guidelines for Medicare payment for therapy services furnished under arrangement. The final rule also sets forth new salary equivalency guidelines for Medicare payments for the reasonable costs of speech language pathology and occupational therapy services furnished under arrangement by an outside contractor. These guidelines will be used by Medicare fiscal intermediaries to determine the maximum allowable cost of those services.

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*'Tighter Rules Needed to Curtail Overcharges for Therapy in Nursing Homes (GAO/HEHS-95-23, March 1995) and Early Resolution of Overcharges for Therapy in Nursing Homes Is Unlikely (GAO/HEHS-96-145, August 1996)*

The HCFA estimates that these new salary equivalency guidelines could save approximately \$260 million over a 3-year period. Although we have not been able to determine the effect of this new rule on the base period if the guidelines had been in existence at that time, in the interim the PPS/SNF rule does not consider these new salary rules in adjusting the base year period costs.

#### **CURRENT STATUS OF PPS/SNF**

The HCFA has developed tentative PPS/SNF rates using two general techniques to ensure that the base cost data was reasonable. The HCFA published an interim final rule on May 12, 1998. This regulation was effective July 1, 1998.

The primary data source for developing the cost basis of the Federal rates is the Medicare allowable costs from hospital-based and freestanding SNF cost reports for reporting periods beginning in FY 1995 (that is, from October 1, 1994 through September 30, 1995). Only those cost reports for periods of at least 10 months but not more than 13 months were included in the data base. In accordance with past policy, HCFA excluded shorter and longer periods on the basis that such data may not reflect a normal cost reporting period and, therefore, may abnormally impact the rate computation.

In accordance with section 1888(e)(4)(A) of the Act, providers that received "new provider" exemptions under section 413.30(e)(2) were excluded from the data base to compute the Federal rates. In addition, allowable costs related to exception payments under section 413.30(f)(1) were excluded; however, other allowable costs for these providers are included in the data base subject to the routine cost limit. Finally, costs related to approved educational activities were excluded from the data base.

Both settled and as-submitted cost reports were used in calculating the Federal rates. However, in accordance with section 1888(e)(4)(A) of the Act, adjustment factors were applied separately to routine and ancillary costs from as-submitted cost reports to make the data reflect adjustments that would normally result from the cost report settlement process. Routine costs were adjusted downward by 1.31 percent, and ancillary costs were adjusted downward by 3.26 percent. These adjustment factors were developed through comparisons of cost data from as-submitted and settled cost reports for providers in the data base from 1995. These factors were validated by examining the relationship between as-submitted and settled cost reports in other years as well.

#### **CONCLUSION AND RECOMMENDATION**

We acknowledge that HCFA has attempted to construct reasonable PPS/SNF rates. However, we are concerned that the methodology used will inflate those rates since HCFA

has not made a downward adjustment for unallowable costs identified in prior audits which would affect the base period amounts. In our opinion, providers will have no incentive to incur such improper costs once PPS/SNF is implemented in July 1998. Therefore, if an adjustment is not made for the inclusion of erroneous payments in the base period, the PPS/SNF rates will be excessive and will enable SNF providers to realize windfall profits.

We recommend that HCFA further review the rates contained in the interim final rule and adjust them downward to reflect unallowable costs for unnecessary services and other improper payments in the base year cost. The interim final rule includes an explanation of the 3-year transition period to the new PPS/SNF. During the transition period, SNFs will receive a payment rate comprised of a blend between the Federal rate and a **facility-specific** rate based on historical costs. An option that HCFA could pursue in the short term to reflect an error rate for improper SNF payments would be to adjust the Federal rate. By adjusting the Federal rate, the impact on the SNF industry would be incremental over the phase-in transition period. For example, if a 20 percent error rate were used to adjust the Federal rate, the impact for the first year would be just 5.00 percent since the Federal rate for the first year of the transition period is 25 percent ( $20\% \times 25\% = 5.00\%$ ). Further adjustments would be made in successive years as the Federal rate increases to 100 percent.

We believe the results of our audits of HCFA's financial statements for FY 1996 and FY 1997 along with other OIG studies can be of help to HCFA in arriving at an adjustment percentage. The FY 1996 and FY 1997 audit results showed over \$43 billion in improper Medicare benefit payments had been made. Approximately \$3 billion of this total reflect SNF payments. Although this value of SNF improper payments should not be used independently as a bench-marking number, we believe it does reflect the fact significant improper SNF payments have been made and are a part of the base period costs. We would be pleased to provide you additional details about our financial statement audit results for your use in adjusting the PPS/SNF values included in the interim final rule. We would also be glad to work with HCFA to perform any additional studies you deem appropriate.

In its response to our **draft** report, HCFA agreed that it and the OIG will examine base year cost data and eliminate inappropriate costs by reducing future payment rates. The HCFA's complete response is included as Attachment IV to this report.

Attachments

## HCFA Financial Statements 1996

A further breakdown of these errors shows that 88 percent of the \$23.2 billion occurred within the first 6 provider types below:

**Estimated Amount of Improper Payments  
(Based on Point Estimate)**

Types of Error (in millions)								
Type of Claim	Lack of Medical Necessity	Insufficient Documentation	No Documentation	Incorrect Coding	Non-covered/Unallowable Service	Remaining Errors	Total	Percentage of Improper Payments <sup>4</sup>
Inpatient PPS	\$3,301	\$869	\$171	\$900		(\$2) <sup>1</sup>	\$5,239	22.59%
Physician	614	1,940	816	1,070	\$329	258	5,027	21.68%
Home Health Agency	1,935	1,681	3			31	3,650	15.74%
Outpatient	356	1,381	905	1	85	82	2,810	12.12%
Skilled Nursing Facility	1,365	555	501			3	2,424	10.45%
Laboratory	146	329	844	(14) <sup>2</sup>	30	2	1,337	5.76%
<b>Subtotal</b>	<b>\$7,717</b>	<b>\$6,755</b>	<b>\$3,240</b>	<b>\$1,957</b>	<b>\$444</b>	<b>\$374</b>	<b>20,487</b>	<b>88.34%</b>
Hospice		179			763		942	4.06%
Inpatient Non-PPS	606					18	624	2.69%
End Stage Renal Disease	24	367				226	617	2.66%
Transportation	181	123	4	3	2		313	1.35%
Ambulatory Surgery	1	172	6	18	10	2	209	0.90%
<b>Total</b>	<b>\$8,529</b>	<b>\$7,596</b>	<b>\$3,250</b>	<b>\$1,978</b>	<b>\$1,219</b>	<b>\$620</b>	<b>\$23,192<sup>3</sup></b>	<b>100.00%</b>
Percentage of Improper Payments <sup>5</sup>	36.78%	32.75%	14.01%	8.53%	5.26%	2.67%		

<sup>1</sup> Negative dollars represent claims that were reimbursed using a rate lower than supported.

<sup>2</sup> Negative dollars represent claims that were reimbursed using a procedure code level lower than supported.

<sup>3</sup> Range of improper payments at the 9.5 percent confidence level is \$17.781 billion to \$28.603 billion. Each dollar estimate is computed consistent with the sampling methodology. The sum of all the dollar estimates equals the overall estimate of \$23.192 billion.

<sup>4</sup> Percentage of the overall estimate of \$23.192 billion by the type of claim.

<sup>5</sup> Percentage of the overall estimate of \$23.192 billion by the type of error.

NOTE: This page is an excerpt from the "Report on the Financial Statement Audit of the Health Care Financing Administration for Fiscal Year 1996," CIN: A-17-95-00096.

HCFA Financial Statements 1997

Types of Errors (dollars in millions)									
Type of Provider	Lack of medical necessity	Insufficient documentation	Incorrect coding	Documents not provided due to extenuating circumstances <sup>1</sup>	NO documentation	Non-or not allowable	All other errors	Total	Percentage of improper payments <sup>2</sup>
Physician	\$376	\$2,415	\$1,698	560	\$178	\$387	\$291	\$5,905	29.11%
Inpatient PPS	2,319	460	1,001	264		17		4,061	20.02%
HHA	2,484	68				1		2,553	12.59%
Outpatient	435	1,478	8		2	32	2	1,957	9.65%
DME	100	80	218	1,009	498	33	1	1,939	9.56%
Transportation	397	3	8	714	18	2	(1) <sup>3</sup>	1,141	5.63%
<b>Subtotal</b>	<b>\$6,111</b>	<b>\$4,504</b>	<b>\$2,933</b>	<b>\$2,547</b>	<b>\$696</b>	<b>\$472</b>	<b>\$293</b>	<b>\$17,556</b>	<b>86.56%</b>

SNF	471	145				13		629	3.10%
Hospice	329	154			138			621	3.06%
End Stage Renal Disease		81	4	375				460	2.27%
Inpatient Non-PPS	448							448	2.21%
Laboratory	76	230	23	19	16	45	10	419	2.07%
Ambulatory Surgery	45	89	15					149	.73%
<b>Total</b>	<b>\$7,480</b>	<b>\$5,203</b>	<b>\$2,975</b>	<b>\$2,941</b>	<b>5850</b>	<b>\$530</b>	<b>\$303</b>	<b>\$20,282</b>	<b>100.00%</b>
Percentage of Improper Payments	36.88%	25.65%	14.67%	14.50%	4.20%	2.61%	1.49%		

<sup>1</sup> Cases in which the providers were under investigation, and we were prohibited from requesting medical records. Because we could not test the validity of these claims, we considered them invalid for determining whether total fee-for-service expenditures were fairly presented. It should be noted these claims could be valid or erroneous (including fraudulent).

<sup>2</sup> Percentage of the overall estimate of \$20.282 billion by the type of claim.

<sup>3</sup> Negative dollars represent claims for which the number of services billed was less than the number of services provided.

<sup>4</sup> The range of improper payments at the 95 percent confidence level is \$12.129 billion to \$28.434 billion. Each dollar estimate is computed consistent with the sampling methodology. The sum of all dollars equals the overall estimate of \$20.282 billion.

NOTE: This page is an excerpt from the "Report on the Financial Statement Audit of the Health Care Financing for Fiscal Year 1996," CIN: A-17-95-00096

SKILLED NURSING FACILITY  
REVIEWS

Name of Facility	HCFA ID Number	OIG ID Number	Report Issued	Amount Questioned	Audit Period
<b>Palm Garden of Pinellas Largo, FL</b>	FL-05-1	A-04-96-0 1118	10/01/96	\$42,870	11/1/94-12/31/95
<b>Stratford Court Boca Raton, FL</b>	FL-05-5	A-04-96-01 124	02/06/97	161,774	11/1/94-12/31/95
<b>Rosemont Health Care Orlando, FL</b>	FL-05-10	A-04-96-0 1125	02/07/97	55,306	11/1/94-12/31/95
<b>Florida Hospital Orlando, FL</b>	FL-05-16	A-04-96-0 1126	02/28/97	52,318	1/1/94-12/31/94
<b>AMI Town &amp; Country Hospital SNF Tampa, FL</b>	FL-05-15	A-04-96-01 127	02/28/97	47,147	1/1/94-12/31/94
<b>Edward White Transitional Care St. Petersburg, FL</b>	FL-05-11	A-04-96-01 128	02/06/97	7,244	1/1/94-12/31/94
<b>American Transitional Care-Rio Pinar Orlando, FL</b>	FL-05-14	A-04-96-01 129	02/28/97	284,378	1/1/94-12/31/94
<b>NHC of St. Petersburg St. Petersburg, FL</b>	FL-05-2	A-04-96-01 130	12/13/96	32,239	1/1/94-12/31/94
<b>IHS of Green Briar Miami, FL</b>	FL-05-7	A-04-96-01 131	02/06/97	202,780	1/1/94-12/31/94
<b>Miami Jewish Home for Aged Miami, FL</b>	FL-051 3	A-04-96-0 1132	02/28/97	391,582	1/1/94-12/31/94
<b>Colonnade Medical Center Lauderdale Lakes, FL</b>	FL-056	A-04-96-0 1134	02/06/97	385,338	1/1/94-12/31/94
<b>Washington Manor Hollywood, FL</b>	FL-05-12	A-04-96-01 135	02/28/97	220,484	1/1/94-12/31/94
<b>Savanah Cay Manor Port St. Lucie, FL</b>	FL-05-3	A-04-96-01 136	12/13/96	354,537	1/1/94-12/31/94
<b>Daytona Nursing Home Daytona Beach, FL</b>	FL-054	A-04-96-01 137	12/13/96	76,130	11/1/94-12/31/95
<b>Lawnwood Reg Mdl Center Hosp. Fort Pierce, FL</b>	FL-058	A-04-96-01 138	02/06/97	95,442	1/1/94-12/31/94
<b>Venice Hospital DP Venice, FL</b>	FL-05-9	A-04-96-01 139	02/06/97	87,105	1/1/94-12/31/94

Name of Facility	OIG ID Number	Report Issued	Amount Questioned	Audit Period
Arbors at Bayonet Point, SNF Hudson, FL	A-04-96-01 146	Jan. 1997	\$113,547	1/1/95-3/31/96
Parker Jewish Geriatric Institute, SNF New Hyde Park, NY	A-04-96-01 147	Apr, 1997	140,188	1/1/95-3/31/96
<b>Intregated</b> Health Services, SNF <b>Burbank, IL</b>	A-04-96-01 148	Mar. 1997	148,955	1/1/95-3/31/96
<b>Presbyterian Hospital, SNF</b> <b>Dallas, TX</b>	A-04-96-01 149	Apr, 1997	198,663	1/1/95-3/31/96
<b>Flagship Convalescent Center, SNF</b> <b>Newport Beach, CA</b>	A-04-96-01 150	Mar. 1997	<u>287,564</u>	1/1/95-3/31/96
<b>Total Questioned</b>			<u><u>\$3.385591</u></u>	



JUN- 8 1998

**DATE:****TO:** June Gibbs Brown  
Inspector General**FROM:** Nancy-km Min DeParle  
Administrator

NMD

**SUBJECT:** Office of Inspector General (OIG) Draft Report: "Review of the Health Care Financing Administration's (HCFA) Development of a Prospective Payment System (PPS) for Skilled Nursing Facilities (SNF)," (A-14-98-00350)

The report raises some important issues relating to the appropriateness of certain costs contained in the 1995 cost base used in the development of the skilled nursing facility (SNF) prospective payment system (PPS) rates that will be promulgated in HCFA's upcoming interim **final** rule. The report recommends HCFA adjust the payment rates downward (including the use of salary equivalency guidelines) to reflect improper costs in the base year. In addition, the report recommends a provision be included in the interim **final** rule to indicate the payment rates will be further reviewed and adjusted downward in the future as necessary.

In response to the concerns raised in the **OIG's** report, the interim **final** rule implementing the SNF PPS (published on May 12, 1998) includes language indicating our intent to address this issue in the future. The preamble of the regulation states that the **OIG**, in conjunction with HCFA, proposes to examine the extent to which the base year cost data used to develop the PPS rates reflects costs that were inappropriately allowed. It further states that if this study reveals the presence of inappropriate costs, HCFA would address this issue in a future proposed rule, or perhaps seek legislation to adjust future payment rates downward.