

**Memorandum**

Date NOV 12 1998  
From June Gibbs Brown  
Inspector General *June Gibbs Brown*  
Subject Review of the Health Care Financing Administration's Development of Medicare's Prospective Payment System for Hospital Outpatient Department Services (A-14-98-00400)  
To Nancy-Ann Min DeParle  
Administrator  
Health Care Financing Administration

Attached is a copy of our final report entitled "Review of the Health Care Financing Administration's Development of Medicare's Prospective Payment System for Hospital Outpatient Department Services."

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 (PPS) for hospital outpatient department (OPD) services as mandated by the Balanced Budget Act of 1997.

While we acknowledge HCFA has done extensive work in order to construct reasonable rates, we are concerned the methodology used will cause the PPS/OPD payment rates to be inflated. The rate-setting methodology does not adjust for factors such as unallowable costs and improper payments which were included in the base period when calculating the fee schedule amounts and targeted expenditure ceiling. We believe hospitals will realize windfall profits at Medicare's expense if these factors are not taken into account.

We are recommending that HCFA, in conjunction with the Office of Inspector General (OIG), further examine the extent to which the base period costs used in setting the fee schedules and expenditure ceiling included unallowable costs. We are also recommending that HCFA and the OIG perform additional studies to assess the extent to which improper payments were included in calculating the expenditure ceiling. If these studies reveal excessive unallowable costs and improper payments, we recommend that appropriate adjustments be made to the fee schedules and expenditure ceiling.

We have also been long concerned about inflated Medicare OPD reimbursements in comparison to amounts paid for similar services performed in other settings, such as ambulatory surgical centers and physicians' offices. Since HCFA intends to move toward setting uniform payment rates across service settings, we believe it is extremely important that payment rates be established to reflect only the costs necessary to efficiently deliver a Medicare service regardless of the service setting. We are recommending that HCFA

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carefully consider the potential efficiencies demonstrated in various service settings when establishing uniform payment rates.

In response to our draft report, HCFA concurred with our recommendations and has added language to the proposed rule on PPS/OPD stating that HCFA and the OIG will further examine the base year costs.

We would appreciate your views and the status of any action taken or contemplated on our recommendations within the next 60 days. Any questions or further comments on any aspect of the report are welcome. Please address them to 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-14-98-00400 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  
MEDICARE'S PROSPECTIVE PAYMENT SYSTEM  
FOR  
HOSPITAL OUTPATIENT DEPARTMENT SERVICES**



**JUNE GIBBS BROWN  
Inspector General**

**NOVEMBER 1998  
A-14-98-00400**

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Subject Review of the Health Care Financing Administration's Development of Medicare's Prospective Payment System for Hospital Outpatient Department Services (A-14-98-00400)

To Nancy-Ann Min DeParle  
Administrator  
Health Care Financing Administration

This final report provides you with our concerns on the Health Care Financing Administration's (HCFA) development of Medicare's prospective payment system (PPS) for hospital outpatient department (OPD) services as required by the Balanced Budget Act (BBA) of 1997.

We acknowledge the importance of having a PPS for OPD services and recognize that HCFA has done extensive work in order to construct reasonable rates. However, we are concerned that HCFA's rate-setting methodology will result in inflated PPS/OPD payment rates. The rate-setting methodology does not take into account that unallowable costs and improper payments were included in the calculation of the fee schedule amounts and targeted expenditure ceiling. As a result, we believe the fee schedule amounts and expenditure ceiling are inflated and an unwarranted financial windfall will be realized by hospitals at Medicare's expense.

We are recommending that HCFA, in conjunction with the Office of Inspector General (OIG), further examine the extent to which the base period costs used in setting the fee schedules and expenditure ceiling included unallowable costs. We are also recommending that HCFA and the OIG perform additional work to assess the extent to which improper payments were included in calculating the expenditure ceiling. If these studies reveal excessive unallowable costs and improper payments, we recommend that appropriate adjustments be made to the fee schedules and expenditure ceiling.

We have also been long concerned about inflated Medicare OPD reimbursements in comparison to amounts paid for similar services performed in other settings, such as ambulatory surgical centers (ASC) and physicians' offices. Since HCFA intends to move toward setting uniform payment rates across service settings, we believe it is extremely important that payment rates be established to reflect only the costs necessary to efficiently deliver a Medicare service, regardless of the service setting. We are recommending that HCFA carefully consider the potential efficiencies demonstrated in various service settings when establishing uniform payment rates.

In response to our draft report, HCFA concurred with our recommendations and has added language to the proposed rule on PPS/OPD stating that HCFA and the OIG will further examine the base year costs.

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## ***BACKGROUND***

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Hospital OPD services are reimbursed under the Medicare Supplementary Medical Insurance (Part B) program. Hospital OPD costs are reported on hospital cost reports and are processed by fiscal intermediaries.

Payments for OPD services generally cover the use of the hospital facility and supplies, but do not include the fees for physicians' professional services. The major OPD categories of service are surgical, medical (including emergency room and clinic services), radiology, laboratory, and end stage renal disease services. Other OPD services include pharmacy, physical therapy, durable medical equipment, blood, and ambulance.

Hospital OPD services have grown to become a significant part of the Medicare program. Reimbursements for OPD services have become one of the fastest growing parts of the Medicare program. For example, between 1990 and 1996 annual Medicare OPD payments almost doubled, while payments for other Medicare Part B services grew by a little over 50 percent. The dramatic growth in Medicare OPD payments is portrayed in the following chart.

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### ***Medicare OPD Payments***

<i>Year</i>	<i>Medicare OPD Payments (In billions)</i>
1974	\$0.3
1980	\$1.4
1983	\$2.7
1987	\$5.8
1990	\$8.4
1993	\$11.9
1996	\$16.3

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## **Current Reimbursement Methodologies For OPD Services**

Prior to 1983, all hospital OPD services were paid for on a reasonable cost basis. Some services, such as emergency room and clinic services, are still reimbursed on a cost basis. However, over the years the Congress has enacted a number of provisions that have altered the way many hospital OPD services are reimbursed. For example, for most hospital-provided ambulatory surgeries Medicare pays the lesser of costs, charges, or a blended payment amount. The blended amount combines a portion of the hospital's costs or charges (whichever is lower) with a portion of the prospective rate that would have been paid had the surgery been performed in a free-standing ASC. Laboratory services are paid using a prospective fee schedule; outpatient dialysis services are paid on the basis of a fixed composite rate; and x-ray services and certain other diagnostic services are blended with the physician fee schedule.

The Congress has recognized the merits and cost-saving potentials of prospective payments in the Medicare program. With the success of PPS for inpatient hospital services, the Congress passed the Omnibus Budget Reconciliation Act (OBRA) of 1986 which required the Secretary to develop a proposal and model payment system for prospective payment for outpatient surgery. The OBRA 1990 required the Secretary to develop a proposal to replace the cost-based reimbursement methodology for all hospital OPD services with a PPS. Although previous PPS proposals for OPD services have not been adopted due to lack of legislative authority, the BBA has given HCFA the legislative authority to implement a PPS for OPD services.

## **Balanced Budget Act Requirements for a Prospective Payment System for Hospital Outpatient Department Services**

Section 4523 of the BBA (Public Law 105-33), enacted in August 1997, amended section 1833 of the Social Security Act by adding subsection (t). This subsection requires implementation of a PPS for OPD services effective with services furnished on or after January 1, 1999. The implementation date has been subsequently delayed until after January 2000 due to the extensive work necessary to bring HCFA's computer systems compliant with Year 2000 requirements.

The Secretary has the authority under the BBA to designate which services will be included in the outpatient PPS, with ambulance services and physical, occupational, and speech therapies specifically excluded because they will be paid on fee schedules established under sections 4531 and 4541 of the BBA. Among the services which will be paid under the outpatient PPS are surgical procedures, clinic visits, emergency room visits, diagnostic services, partial hospitalization services, and cancer chemotherapy. Services which will initially be excluded from the outpatient PPS include laboratory services, orthotics, prosthetics, and chronic dialysis.

As required by the BBA, HCFA classified covered OPD services into groups which are related clinically and in terms of resource use. There are 346 groups, termed Ambulatory Payment Classifications (APC). For each APC group, the BBA required a weight be developed based on the median cost of services included in the group. The statute specified that the median cost of services be derived using *hospital OPD claims from 1996 and the most recent available cost reports*. The weights for each group were converted to fee schedule payment rates using a conversion factor which takes into account group weights and the projected volume of services of each group. The BBA required the conversion factor be calculated so that outpatient PPS payments in Calendar Year (CY) 1999 will equal the projected amount that would have been *payable* from the Medicare trust fund in 1999 for covered OPD services under current (non-PPS) payment methodologies plus the amount of beneficiaries' coinsurance payments calculated under the new PPS system. In addition, as required by the BBA, HCFA adjusted the fee schedules to reflect differences in labor-related costs across geographic areas. The BBA also authorizes other adjustments may be made in a budget-neutral manner to ensure equitable payments.

The BBA also gave the Secretary the authority to develop a method for controlling unnecessary increases in the volume of hospital OPD services when the outpatient PPS is implemented. If, under the volume control methodology, an increase in the volume of services causes payments to exceed the methodology's projected levels, the Secretary may adjust the PPS/OPD conversion factor. Initially, HCFA is proposing a volume control measure for services furnished in CY 2000. The proposed volume control measure involves an expenditure ceiling based on an updated projection of the amounts that would have been *payable* from the Medicare trust fund in 1999 for covered OPD services under current (non-PPS) payment methodologies plus the amount of beneficiaries' coinsurance payments calculated under the new system, taking into account projected changes in volume and intensity of services and in enrollment. If the volume of services causes expenditures to exceed the target for CY 2000, HCFA is proposing to adjust the update to the conversion factor for CY 2002. For subsequent years, HCFA will propose an appropriate method for determining volume control expenditure targets after further analysis.

Under the BBA, HCFA is required to periodically review and update groups, weights, and adjustments to the fee schedules. The fee schedules will be updated annually by the market basket increase minus one percentage point for the years 2000 through 2002, and by the market basket percentage increase in subsequent years.

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## ***SCOPE***

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The objective of our review was to determine if the methodology developed by HCFA to establish PPS fee schedules for OPD services as required by the BBA is reasonable. To accomplish our objective, we:

- ▶ reviewed applicable laws, regulations, and HCFA manual references concerning OPD reimbursement methodologies;
- ▶ reviewed the provisions of the BBA applicable to OPD services;
- ▶ reviewed drafts of the proposed regulations implementing a PPS for OPD services;
- ▶ discussed the proposed implementing regulations with HCFA officials;
- ▶ reviewed prior reports issued by the OIG pertaining to Medicare reimbursements in general and to hospital OPD providers in particular;
- ▶ reviewed prior proposals and studies dealing with implementing a PPS for OPD services; and
- ▶ reviewed literature and prior studies on Medicare inpatient and outpatient usage and expenditure trends.

A listing of reports supporting our concerns about the factors which will inappropriately inflate the PPS/OPD payment rates is included as Attachment I.

This limited scope review was performed in accordance with generally accepted government auditing standards. Our work was performed February through May 1998 at HCFA's central office.

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## ***FINDINGS AND RECOMMENDATIONS***

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According to HCFA's proposed regulations and our discussions with HCFA officials, adjustments were not made to the PPS/OPD fee schedules and the proposed volume control

expenditure ceiling to take into account factors which may cause the payment rates to be inflated. We are concerned about the reliability of the cost data used to compute the fee schedules and the expenditure ceiling. Specifically, we are concerned that the base year costs used to derive the fee schedules and expenditure ceiling included factors such as unallowable costs and improper payments. We believe these factors could have a significant impact on the PPS/OPD payment rates and could result in hospitals realizing windfall profits at Medicare's expense.

- \* We are also concerned that hospital OPD reimbursements have been inflated in comparison to amounts paid for similar services performed in other settings. As HCFA intends to move

toward establishing uniform payment rates across settings, we believe it is extremely important that payment rates be set so they reflect only the costs necessary to efficiently deliver a Medicare service regardless of the service setting.

### **Unallowable Costs**

Although the BBA required HCFA to use *audited* cost report data to develop a PPS for home health services, the BBA required HCFA to use the most recent available, but not necessarily audited, cost reports when developing the PPS for OPD services. In developing the PPS/OPD, HCFA used settled cost reports when available and, if settled cost reports were not available, HCFA calculated an adjustment factor to offset the estimated difference between settled and unsettled cost reports on an individual hospital basis. Although HCFA's cost report settlement process was designed to prevent the shifting of inappropriate and unnecessary costs to the Medicare program, budget constraints limit provider audit activity to specific issue areas or cost report line items and only covers a limited number of providers. Due to the limited scope and number of audits, there is limited assurance that amounts eventually paid to the providers through the final cost report settlement process meet Medicare guidelines for reasonableness and appropriateness. The General Accounting Office identified the decline in cost report audits due to funding as one of the factors which makes Medicare highly vulnerable to waste, fraud, and abuse.

Our prior audit work has identified substantial unallowable costs included on hospitals' Medicare cost reports. We did a series of audits of hospitals' general and administrative and fringe benefit costs included in their cost reports to determine if these costs were allowable, reasonable, and allocable under the Medicare program. Our audits found significant unallowable and questionable costs included in hospitals' cost reports. Unallowable costs included in hospital cost reports directly affect the current Medicare reimbursement for OPD services.

We have concerns that the calculations of the PPS/OPD fee schedules and volume control expenditure ceiling included the unallowable costs included in hospitals' cost reports, thereby inflating the fee schedules and expenditure ceiling. We believe these costs should be considered when developing the PPS/OPD fee schedules and expenditure ceiling.

We are therefore recommending HCFA, in conjunction with the OIG, further study the extent to which the base period costs included unallowable costs. If this analysis reveals excessive unallowable costs, we recommend that an appropriate adjustment be made to the fee schedules and expenditure ceiling.

## Improper Payments

We are also concerned that HCFA's methodology for setting PPS/OPD reimbursements did not take into account the estimated costs of improper payments for Medicare services that were included when calculating the volume control expenditure ceiling. Over the years, the OIG has identified several areas of payment improprieties in Medicare's reimbursement for OPD services, including improper payments for unnecessary OPD services, OPD payments that should have been part of hospitals' inpatient PPS reimbursement rates, upcoding, noncovered outpatient psychiatric services, and Medicare credit balances for OPD services.

In addition, as part of our audit of HCFA's Fiscal Year (FY) 1996 financial statements, we undertook a comprehensive review of Medicare claims expenditures and supporting medical records. This was the first time in the history of the Medicare program that a comprehensive, statistically valid sample of Medicare fee-for-service claims had ever been taken to determine if the payments were made in accordance with Medicare law and regulations. As presented in our *"Report on the Financial Statement Audit of the Health Care Financing Administration for Fiscal Year 1996"* we found that several areas of the Medicare program, including payments for OPD services, are vulnerable to improper provider billing practices. Our audit 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. *Our audit results indicated that about 12.1 percent of the total incorrect payments, or about \$2.8 billion, were related to OPD services.*

Our FY 1997 review confirmed our prior findings that the Medicare program is inherently vulnerable to incorrect provider billing practices. We estimated that improper Medicare benefit payments made during FY 1997 totaled \$20.3 billion, or about 11 percent of the \$177.4 billion in processed fee-for-service payments reported by HCFA. The estimated range of the improper payments at the 95 percent confidence level is \$12.1 billion to \$28.4 billion, or about 7 percent to 16 percent. *Our audit results indicated that about 9.7 percent of the total incorrect payments, or about \$2 billion, were related to OPD services.*

Included as Attachment II is an excerpt from our FY 1997 financial statement audit report detailing the estimated overall and OPD-specific improper payments made during FY 1996 and FY 1997.

We believe our audits have demonstrated that overpayments have occurred in Medicare's reimbursements for OPD services and these overpayments are too significant to be ignored when calculating the PPS/OPD expenditure ceiling. Although we do not believe the value of improper OPD payments identified in our audits should be used independently to determine a reduction in the OPD expenditure ceiling, we believe our findings could be used in

conjunction with other work to develop an appropriate adjustment. We would be pleased to provide you with additional details about our prior audit results (as listed in Attachment I).

We recommend that HCFA, in conjunction with the OIG, do further work to assess the extent to which the base period used in calculating the expenditure ceiling included improper payments which were not made in accordance with existing Medicare law and regulations. If this work reveals excessive improper payments, we recommend an appropriate adjustment to the expenditure ceiling be made.

### **Setting Payment Rates Across Service Settings**

During the past years, there has been a significant increase in Medicare OPD expenditures. This increase has been attributable to a number of causes, including:

- ▶ the inception of Medicare PPS for hospital inpatient services in October 1983 which offered hospitals financial incentives to shift care from inpatient settings to less costly OPD settings;
- ▶ sophisticated advances in medical technologies have made a growing number of surgical and diagnostic procedures feasible on an outpatient basis;
- ▶ development of anesthetics and analgesics that reduce side effects and discomfort after surgery and encouragement by physicians for patients to become ambulatory soon after surgery to reduce recovery time have made OPD services a feasible place of treatment;
- ▶ managed care plans' incentives to use less costly outpatient settings may influence physicians who participate in both fee-for-service and managed care programs to use outpatient settings when selecting treatments for their fee-for-service patients; and
- ▶ utilization review policies which encourage the use of cost-effective OPD services.

As a result of these factors, many treatment and diagnostic services have migrated from hospital inpatient to the outpatient settings. With this migration of services, costs also migrated from inpatient to outpatient settings. Studies have documented that since the implementation of inpatient PPS, hospitals have shifted overhead costs from inpatient to outpatient settings. For example, in 1990, the Center for Health Policy Studies for the Office of the Assistant Secretary of Planning and Evaluation (ASPE), issued a report with the results of a study to determine whether hospitals shifted costs through a comparison of resources needed and costs reported. The study found that hospitals have shifted overhead costs to

OPDs to such an extent that hospitals reported more OPD costs than resources consumed in producing services. The report concluded that hospital OPD costs were overstated and this was attributable to hospitals shifting indirect costs from inpatient to outpatient settings.

In its proposed rule implementing outpatient PPS, HCFA also acknowledged that since the inception of inpatient PPS, hospitals have shifted some overhead costs from inpatient to outpatient settings, thereby, to the extent shifting has occurred, allowing hospitals to receive reimbursement twice for the same costs. These overhead costs were included when deriving inpatient PPS reimbursements and, as these costs shifted and were allocated to the OPD setting, they are paid for again by Medicare under OPD cost reimbursement.

The OIG has long been concerned about inflated OPD reimbursements. In 1989 and 1991, we issued reports which dealt with excessive Medicare reimbursements for services performed in hospital OPDs in comparison to the amounts paid for similar services performed in ASC settings. Prior HCFA studies also highlighted this disparity, and HCFA agreed with the recommendations in our reports to establish greater parity of payment levels between services performed in OPD settings and those performed in ASCs. Although legislation has subsequently reduced Medicare payments for some OPD services, we believe that an unjustifiable disparity between Medicare payments to hospital OPDs and ASCs still exists.

We recognize cost differences between OPD, ASC, and physician's office settings could exist for a number of reasons including severity of illness, unique regulatory requirements on hospitals, overhead allocation practices, and inefficiencies in hospital settings. However, payment rates should be set so they reflect only the costs necessary to efficiently deliver a Medicare service regardless of the service setting. As recently indicated by the Medicare Payment Advisory Commission, setting the appropriate PPS/OPD rates is especially important so incentives do not exist to shift services between settings for financial reasons rather than clinical appropriateness.

We are concerned that using hospital data with known inflated and shifted costs when calculating the PPS/OPD fee schedules will not take into account the efficiencies that are possible as evidenced by providers in other settings.

Our concerns have also been raised by others. The Assistant Secretary for Management and Budget (ASMB), ASPE, and the Prospective Payment Assessment Commission also raised the concern of basing PPS/OPD fee schedules on hospital data with known inflated and shifted costs. For example, in commenting in 1992 to a HCFA proposal to put OPD services under a PPS, ASMB had concerns that: "Given the evidence of cost-shifting to outpatient services that may have occurred after implementation of the PPS for inpatient services, it is likely that PPS rates based on hospital costs will overpay hospitals for outpatient services. ASMB's concern is that a payment system based on these inflated costs will not encourage the efficiency that a PPS policy should achieve. ASMB is also concerned that once the

system is put in place and the rates are set, it may be difficult to change these rates as HCFA obtains better cost information.”

Since HCFA intends to move in the direction of establishing uniform payment rates across service settings, we believe it is extremely important that payment rates be set to reflect only the costs necessary to efficiently deliver a Medicare service regardless of service setting. We recommend HCFA carefully consider the historical and potential efficiencies demonstrated in various service settings when establishing uniform payment rates.

### **Conclusions and Recommendations**

We recognize that HCFA has done extensive work to construct reasonable PPS/OPD rates. However, we are concerned that the rate-setting methodology does not take into account that unallowable costs and improper payments were included when calculating the fee schedule amounts and expenditure ceiling. Since the outpatient PPS fee schedules and expenditure ceiling are based on prior Medicare outpatient reimbursements, we believe hospitals will realize windfall profits at Medicare's expense if these factors are not taken into account.

We are, therefore, recommending HCFA:

- ▶ in conjunction with the OIG, further examine the extent to which unallowable costs were included in the base period when calculating PPS/OPD fee schedules and expenditure ceiling. If excessive unallowable costs were included in the calculations, we recommend appropriate adjustments to the fee schedules and expenditure ceiling be made; and
- ▶ in conjunction with the OIG, do further work to assess the extent to which the base period used in calculating the expenditure ceiling included improper payments which were not made in accordance with existing Medicare law and regulations. If this work reveals excessive improper payments were included in the expenditure ceiling calculations, we recommend an appropriate adjustment be made to the expenditure ceiling.

We are also concerned about the inflated OPD reimbursements in comparison with amounts paid for similar services performed in other settings. As HCFA intends to move toward establishing uniform payment rates across service settings, we believe it is extremely important that appropriate rates be set so they reflect the cost of efficiently providing a Medicare service regardless of where the service is performed. Therefore, we are recommending that HCFA:

- ▶ carefully consider the potential efficiencies demonstrated in various service settings when establishing uniform payment rates.

In its response to our draft report, HCFA agreed with our recommendations, stating "continuing to assess the accuracy of both the PPS rates and the expenditure ceiling is critical to the success of outpatient PPS". The HCFA added language to the proposed rule issued in September 1998 stating that HCFA and the OIG will further examine the base year costs to determine if unallowable costs and improper payments were included in the PPS/OPD calculations. The HCFA also stated it plans to further examine the differences in payments across sites in order to develop recommendations for possible legislative changes to establish uniform payment rates. The full text of HCFA's comments is included as Attachment III.

## **REPORTS SUPPORTING OIG's CONCERNS**

### *OIG Reports - Unallowable Costs*

- National Review of General and Administrative and Fringe Benefit Costs At Hospitals (A-03-92-00017) *Issued August 1994*

### *OIG Reports - Improper Payments for Medicare Services*

- Report on the Financial Statement Audit of the Health Care Financing Administration for Fiscal Year 1997 (A-17-97-00097) *Issued April 1998*
- Report on the Financial Statement Audit of the Health Care Financing Administration for Fiscal Year 1996 (A-17-95-00096) *Issued July 1997*
- Improper Medicare Payments to Hospitals for Nonphysician Outpatient Services Under the Prospective Payment System (A-01-95-00508) *Issued May 1996*
- Status Report - Office of Inspector General/Department of Justice Joint Project--Medicare Nonphysician Outpatient Bills Submitted by Hospitals (A-03-94-00021) *Issued August 1995*
- Expansion of the Diagnosis Related Group Payment Window (A-01-92-00521) *Issued July 1994*
- Nationwide Review of Improper Payments to Hospitals for Nonphysician Outpatient Services Under the Prospective Payment System (A-01-91-00511) *Issued December 1992*
- Improper Payments to Hospitals for Nonphysician Services Under the Prospective Payment System (A-01-90-00516) *Issued August 1990*
- Millions in Improper Payments to Hospitals for Nonphysician Outpatient Services Under the Prospective Payment System (A-01-86-62024) *Issued July 1988*
- Update on Findings Developed in Our National Review of Medicare Beneficiary Accounts With Credit Balances (A-03-92-00010) *Issued December 1992*

- Review of Medicare Outpatient Accounts Receivable with Credit Balances at Selected Hospitals (A-03-91-00028) *Issued August 1991*
- Medical Necessity of Hospital Outpatient Services (A-07-92-00504) *Issued March 1993*
- Review of Ambulatory Surgical Services Performed in Hospital Outpatient Departments - Procedure Coding Differences (A-01-94-00507) *Issued December 1994*
- Psychiatric Outpatient Services: The Arbour-Hri Hospital (A-01-97-00526) *Issued March 1998*
- Psychiatric Outpatient Services: The Newton-Wellesley Hospital (A-01-98-00506) *Issued March 1998*

#### *OIG Reports - Setting Payment Rates Across Service Settings*

- Medicare Reimbursement for Hospital Outpatient Department Services (A-14-89-00221) *Issued March 1991*
- Reimbursement for Outpatient Facility Services (OEI-09-88-01003) *Issued May 1989*

#### *OIG Concerns Raised by Others*

- Medicare Payment Advisory Commission--Report to the Congress: Medicare Payment Policy *Issued March 1998*
- General Accounting Office--High Risk Series-Medicare *Issued February 1997*
- Assistant Secretary for Management and Budget--Comments on Report to Congress on PPS for Hospital Outpatient Services *Issued October 1992*
- Assistant Secretary for Planning and Evaluation--Comments on Report to Congress on Hospital Outpatient Prospective Payment *Issued October 1992*
- Center for Health Policy Studies for the Office of the Assistant Secretary of Planning and Evaluation--Report on Clinic and Emergency Departments Resource Costs *Issued April 1990*
- Prospective Payment Assessment Commission--Medicare Payment for Hospital Outpatient Surgery *Issued June 1989*

**Comparison of FYs 1996 and 1997 Types of Provider Categories  
Highest Estimated Dollars in Improper Payments**

Type of Provider		1997		1996	
		Estimated Dollars in Improper Payments (in millions)	Improper Payments as a Percent of Total	Estimated Dollars in Improper Payments (in millions)	Improper Payments as a Percent of Total
<b>1</b>	<b>Physician</b>	<b>\$5,905</b>	<b>29.11%</b>	<b>\$5,027</b>	<b>21.67%</b>
	<i>Documentation</i>	3,153	15.55%	2,756	11.88%
	<i>Medically unnecessary/noncovered</i>	763	3.76%	943	4.07%
	<i>Incorrectly coded</i>	1,698	8.37%	1,070	4.61%
	<i>Remaining errors</i>	291	1.43%	258	1.11%
<b>2</b>	<b>Inpatient PPS</b>	<b>4,061</b>	<b>20.02%</b>	<b>5,239</b>	<b>22.59%</b>
	<i>Documentation</i>	724	3.57%	1,040	4.49%
	<i>Medically unnecessary/noncovered</i>	2,336	11.52%	3,301	14.23%
	<i>Incorrectly coded</i>	1,001	4.93%	900	3.88%
	<i>Remaining errors</i>			(2)	-0.01%
<b>3</b>	<b>Home Health Agency</b>	<b>2,553</b>	<b>12.59%</b>	<b>3,650</b>	<b>15.74%</b>
	<i>Documentation</i>	68	0.34%	1,684	7.26%
	<i>Medically unnecessary/noncovered</i>	2,485	12.25%	1,935	8.34%
	<i>Remaining errors</i>			31	0.14%
<b>4</b>	<b>Outpatient</b>	<b>1,957</b>	<b>9.65%</b>	<b>2,810</b>	<b>12.12%</b>
	<i>Documentation</i>	1,480	7.30%	2,286	9.86%
	<i>Medically unnecessary/noncovered</i>	467	2.30%	441	1.90%
	<i>Incorrectly coded</i>	8	0.04%	1	0.01%
	<i>Remaining errors</i>	2	0.01%	82	0.35%
	<b>Subtotal</b>	<b>14,476</b>	<b>71.37%</b>	<b>16,726</b>	<b>72.12%</b>
<b>5</b>	<b>Other Types of Providers</b>	<b>5,806</b>	<b>28.63%</b>	<b>6,466</b>	<b>27.88%</b>
	<i>Documentation</i>	3,569	17.60%	3,080	13.28%
	<i>Medically unnecessary/noncovered</i>	1,959	9.66%	3,128	13.49%
	<i>Incorrectly coded</i>	268	1.32%	7	0.03%
	<i>Remaining errors</i>	10	0.05%	251	1.08%
	<b>Total</b>	<b>\$20,282</b>	<b>100.00%</b>	<b>\$23,192</b>	<b>100.00%</b>

Note: This page is excerpted from the "Report on the Financial Statement Audit of the Health Care Financing Administration for Fiscal Year 1997" (A-17-97-00097)



## Memorandum

**DATE:** SEP 21 1998

**TO:** June Gibbs Brown  
Inspector General

**FROM:** Nancy-Ann Min DeParle **NMD**  
Administrator

**SUBJECT:** Office of Inspector General (OIG) Draft Report: "Review of the Health Care Financing Administration's (HCFA) Development of a Prospective Payment System for Hospital Outpatient Department Services," (A-14-98-00400)

We reviewed the above-referenced report that examines the methodology developed by HCFA that was used to establish prospective payment system (PPS) fee schedules for hospital outpatient department services (OPD). The report acknowledges the extensive work done by HCFA to construct reasonable PPS/OPD payment rates.

The report expresses concern, however, that the rate-setting methodology does not adjust for factors such as unallowable costs and improper payments which were included in the base period when calculating the fee schedule amounts and targeted expenditure ceiling.

We concur with the report recommendations. Specific comments follow:

### OIG Recommendation

HCFA should, in conjunction with the OIG, further examine the extent to which unallowable costs were included in the base period when calculating PPS/OPD fee schedules and the expenditure ceiling. If excessive unallowable costs were included in the calculations, we recommend that appropriate adjustments to the fee schedules and expenditure ceiling be made.

### HCFA Response

We concur. Additional audits of base year cost reports could assist HCFA in identifying unallowable costs. The Balanced Budget Act of 1997 (BBA) requires HCFA to use settled cost reports, but not necessarily audited cost reports when setting PPS rates. It is possible that payments made to outpatient providers for services in 1996 were not subjected to a cost report audit until late fiscal year (FY) 1997 or even FY 1998. HCFA did, however, use an adjustment factor to offset the estimated difference between settled

and unsettled cost reports on an individual hospital basis. Based on comments the OIG submitted during the clearance of HCFA's regulation on outpatient PPS, we added language to the preamble to say that in conjunction with the OIG, HCFA will further examine the issues.

OIG Recommendation

HCFA should, in conjunction with the OIG, do further work to assess the extent to which the base period used in calculating the expenditure ceiling included improper payments which were not made in accordance with existing Medicare law and regulations. If this work reveals excessive improper payments were included in the expenditure ceiling calculations, we recommend an appropriate adjustment be made to the expenditure ceiling.

HCFA Response

We concur. Continuing to assess the accuracy of both the PPS rates and the expenditure ceiling is critical to the success of outpatient PPS. Based on comments the OIG submitted during the clearance of HCFA's regulation on outpatient PPS, we added language to the preamble to say that in conjunction with the OIG, HCFA would further examine the issues.

OIG Recommendation

HCFA should carefully consider the potential efficiencies demonstrated in various service settings when establishing uniform payment rates.

HCFA Response

We concur. Establishing uniform rates will guarantee that payment rates reflect only the costs necessary to efficiently deliver a Medicare service regardless of service setting. Although we need legislative authority to make changes to how payment rates are determined in the various ambulatory settings, we do plan to examine the differences in payments across sites and other issues (e.g., availability of services in various sites, beneficiary coinsurance, etc.), in order to develop recommendations for legislative changes.

Technical Comments

Page 4, paragraph 2, states that HCFA will use a budget neutral target amount required by the BBA as an expenditure ceiling in FY 1999 and will recoup payments made in excess of that ceiling in FY 2001. This statement should be modified. The BBA requires that the fee schedules be calculated in a manner so that the estimated total amount paid will be equal to the amount that would otherwise be paid by Medicare for OPD services in 1999. There is also a section in BBA that gives the Secretary the authority to make a volume adjustment. The Secretary is required to develop a method for controlling unnecessary increases in the volume of services. If the Secretary determines that under such a

methodology the volume of services has increased beyond amounts established through such methodology, the Secretary may adjust the update to the conversion factor.

The BBA, thus, does not stipulate what the volume control mechanism is to be. The proposed rule for the OPD PPS was published in the Federal Register on September 8. This rule does propose a volume control mechanism for the first year of operations (1999). The rule was published with a comment period and, therefore, the final regulation could potentially contain revisions..

Thus, we suggest that the OIG's characterization of the expenditure ceiling and the corresponding recoupment in the year 2001 be modified to make it clear that the Secretary is given the authority to develop a volume control system, that the system will likely involve an expenditure target and corresponding recoupment, and that such a system will be included in the proposed rule.

Regarding the inclusion of unallowable costs and improper payments in the base period, if either or both conditions exist, the adjustments that would need to occur in the OPD PPS are more than the application of a uniform deflator. For instance, if a set of codes was found to have a disproportionate amount of unallowable costs associated with it, then the group assignment of the codes as well as the calculation of the weights and rates would be skewed. To incorporate unallowable costs into specific code assignments would provide improper incentives to the OPD delivery system. Conversely, if the OIG analysis provides evidence that all unallowable costs and improper payments are equally distributed among all codes, then we could employ a uniform deflator.

We suggest that Medicare be included in the title of the report to more accurately reflect the subject matter of the report.