HOSPITAL PROSPECTIVE PAYMENT SYSTEM (PPS) RATES ARE INFLATED BECAUSE THE COSTS OF EXEMPT UNITS WITHIN HOSPITALS WERE NOT REMOVED FROM BASE YEARS COSTS

OFFICE OF INSPECTOR GENERAL

OFFICE OF AUDIT

CIN: A-01-86-62017

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandum

Date APR - 6 1987

From Richard P. Kusserow
Inspector General

Subject OIG Final Audit Report - Hospital Prospective Payment System (PPS) Rates Are Inflated Because The Costs Of Exempt Units Within Hospitals Were Not Removed From Base Years Costs - CIN: A-01-86-62017

To William L. Roper, M.D.
Administrator
Health Care Financing Administration

Attached for your review and comment is a copy of the subject final audit report. The report points out that psychiatric, rehabilitation and alcoholic units of general care hospitals which meet specific regulatory requirements are exempt from PPS and are reimbursed based on Medicare reasonable cost reimbursement principles. Therefore, the operating costs of these units should have been excluded from the base year costs when establishing the PPS rates. However, we determined that the operating costs associated with the exempt units were included in the calculations of the PPS rates. The costs of operating exempt units are usually much higher than the costs of operating other general care units of a hospital. Consequently, by including the exempt unit costs in the PPS rate calculation, the average cost to Medicare for each PPS discharge is inflated.

Based on our review of 62 hospitals with 75 exempt units, we determined that these hospitals received excessive reimbursement of about $16.1 million for fiscal year 1984. Our analysis disclosed that alcoholic exempt units made up only a small portion of this amount and wide cost variances exist among the individual alcoholic units included in our review. Consequently, we el minated these units from our estimates. We estimate that the inclusion of the loss for psychiatric and rehabilitation exempt hospital units in the computation of PPS base year costs will result nationwide in excessive reimbursements of over $1 billion ($595 million related to inflated hospital specific rates and $524 million related to inflated Federal rates) during the four year PPS transition period. Further, when PPS reimbursement is based entirely on the Federal rate in fiscal year 1988, estimated excessive reimbursements will total about $268 million annually.

In determining whether the excessive payments made to hospitals could be recovered from the hospitals involved, we obtained a legal opinion from the Office of General Counsel (OGC). The OGC advised that the current legislative statutes concerning PPS preclude correcting the exempt unit problem prospectively through rebasing the PPS rate or retrospectively by adjusting the hospital specific portion of the PPS rate. However, the OGC commented that adjustments for the excessive payments may be possible based on reasonable cost reimbursement principles applicable to the exempt units. The OGC pointed out that this method of recovery would require HCFA to revise the Medicare reasonable cost reimbursement rules to permit such adjustments. Also, OGC advised that although it is the only apparent solution to the problem we uncovered, there would be some practical difficulties.

In summary, we believe that the exempt unit situation adds to the number of problems found in the base year hospital cost data used to develop the initial PPS rates. In this regard, the OIG and the U.S. General Accounting Office have previously issued six reports discussing areas of overstatement in the 1981 cost data HCFA used for PPS rate setting. These audit issues involve (1) the inappropriate inclusion of capital costs in PPS rates, (2) excessive allowances for indirect medical education and (3) the use of unaudited cost reports. Consequently, to preclude unnecessary expenditures beyond the transition period, the need to rebase PPS rates is essential and prior OIG reports have recommended this action.

To completely correct the exempt unit cost problems discussed in this report, we also recommend that HCFA revise the appropriate regulations for settling hospital exempt unit cost reports to permit adjustments for excessive reimbursements resulting from the inclusion of exempt unit costs in the PPS rates. The recommended adjustments are limited to overpayments associated with the inflated hospital specific portion of the PPS rates in effect during the PPS transition period (October 1983 - September 1987). We are not recommending adjustment for excessive payments associated with the Federal portion of the PPS rate for the transition period, because only about 1,000 of the 5,400 PPS hospitals affected by the inflated Federal rate have exempt units and would be required to file cost reports to be used for settlement purposes in accordance with cost reimbursement principles.

In commenting on our recommendations for correcting the exempt unit issue, HCFA stated that our estimates of excessive payments are not accurate because we did not consider the additional costs incurred by hospitals to make changes to their operations in order to meet the criteria for exempt unit status. In addition, HCFA stated that recovery of the excessive payments through the cost report settlement process was impractical and of questionable legality. Therefore, HCFA concluded that recovery of excessive payments would not be appropriate.

As indicated in our report, however, a number of discussions we held with hospital and intermediary provider audit personnel in Connecticut and Pennsylvania disclosed that hospitals did not require major alterations to their existing psychiatric and rehabilitation units to meet the HCFA criteria for exempt status. Consequently, there were no significant costs incurred by the hospitals during the first year of PPS. Also, during our review, we were advised by the OGC that there is a legal basis to permit recovery of the excessive payments through the cost report settlement process.

We would appreciate receiving a status report, within 60 days, of any action taken or planned on our recommendations. Copies of this report are being provided to other Departmental officials.

Attachment

SUMMARY

Psychiatric, rehabilitation and alcoholic hospital units which meet specific regulatory requirements are exempt from PPS. These units are reimbursed actual costs using Medicare's cost reimbursement principles. As of June 1985, HCFA had approved exemptions for 1,261 hospital units comprised of 673 psychiatric, 324 rehabilitation and 264 alcoholic units. Although these hospital units are exempt from PPS, their costs and discharges were included in the 1981 data base HCFA used to develop the Federal portion of PPS rates and in the 1982 data base intermediaries used to develop the hospital specific portion of the PPS rate.

Using data from 75 exempt units in 7 states, we calculated the approximate impact of including the exempt unit costs and discharges in setting the hospital specific PPS rates for 1984. By including the exempt unit costs and discharges in the base, hospital specific rates relating to 60 exempt units increased resulting in excessive PPS payments of $17 million. Conversely, hospital specific rates for 15 exempt units decreased resulting in lower payments of $900,000. The PPS rates are inflated because the average costs of a discharge from an exempt unit are generally much higher than the average costs of an acute care discharge. The costs and discharges of exempt units are also included in the 1981 hospital data used to develop the Federal rate. The Federal rate, therefore, which applies to all PPS hospitals, is also overstated.

During the course of our analysis, we noted that alcoholic exempt units made up only a small portion of the excessive reimbursements as determined in our calculations. In addition, the calculations for the alcoholic exempt units disclosed wide cost variances between individual alcoholic units. It was our opinion that the results of our analysis of the alcoholic units would not provide an accurate nationwide estimate of the potential excessive Medicare payments related to these types of units. Consequently, we eliminated the alcoholic units from any further estimates. Therefore, considering the results of our review of psychiatric and rehabilitation exempt units, we estimate that during the four year transition period ending September 30, 1987, the inflated hospital specific portion of the PPS rate will result in excessive reimbursements to hospitals of about $595 million (See ATTACHMENT III). Similarly, for the same period, the inflated Federal portion of the PPS rate will result in excessive reimbursements to hospitals of about $524 million (See ATTACHMENT IV). If this condition is not corrected, we further estimate that excessive reimbursements will amount to $268 million (See ATTACHMENT V) annually beginning with fiscal year 1988, the first year that PPS will be based entirely on a Federal rate. ATTACHMENT I to this

report provides a detailed explanation of the method used to estimate the excessive payments made to hospitals nationwide.

In determining whether the excessive payments made to hospitals could be recovered, we obtained a legal opinion from the Office of General Counsel (OGC). The OGC advised that the current legislative statutes concerning PPS preclude correcting the exempt unit problem prospectively through rebasing of the rate or retroactively by adjusting the hospital specific rate. However, the OGC believes that if HCFA modified its existing regulations, adjustments based on reasonable cost reimbursement principles may be possible. In this respect, excessive PPS payments received by hospitals would be offset during the cost settlement process against the hospital exempt unit cost.

We recommend that HCFA initiate a legislative change to rebase PPS rates concurrent with the use of a 100 percent Federal rate beginning October 1, 1987. Pending action to rebase, we are also recommending that HCFA consider the information in this report in establishing the level of increase in PPS rates during their annual update of the rates.

Further, we recommended that HCFA revise the appropriate regulations for settling hospital exempt unit cost reports to permit adjustments for excessive reimbursements resulting from the inclusion of exempt unit costs in the PPS rates. Such adjustments should be processed during the settlement of future cost reports. The recommended adjustments are limited to overpayments associated with the inflated hospital specific portion of the PPS rates in effect during the PPS transition period (October 1983 - September 1987). We estimate that the excessive reimbursements, as they relate to the hospital specific portion of the PPS rate, amount to about $595 million through fiscal year 1987.

We are not recommending adjustment for excessive payments related to the Federal portion of the PPS rate for the transition period, because only about 1,000 of the 5,400 PPS hospitals affected by the inflated Federal rate have exempt units and are required to file cost reports specifically related to their exempt units which would require settlement in accordance with cost reimbursement principles.

With respect to our recommendation to rebase PPS rates, HCFA has indicated previously that several studies have been conducted on this issue, but no final decisions have been made concerning rebasing or updating PPS rates. In response to this report, HCFA stated that the OIG report was supportive of their decision to freeze payment levels for fiscal year 1986.

Further, HCFA indicated that our estimates of excessive payments are not accurate because we did not consider the additional costs incurred by hospitals to make changes to their operations in order to meet the criteria for exempt unit status. In addition, HCFA's response stated that recovery of the excessive payments through the cost report settlement process may not have legal supportability. Therefore, HCFA concluded that recovery of excessive payments noted in the report would not be permissible or appropriate. (See APPENDIX).

We believe that the following additional points should be considered in the resolution of this report:

(1) We held a number of discussions with hospital and intermediary provider audit personnel in Connecticut and Pennsylvania and were informed that hospitals did not require much in the way of modification to existing psychiatric and rehabilitation facilities to meet the HCFA criteria for exempt status. There were no significant or costly alterations to these facilities during the first year of PPS. Therefore, we are confident that our methodology for estimating the excessive payments is reasonable.

(2) During the review, we were advised by the OGC that there appeared to be a valid legal basis to permit recovery of the excessive payments through the cost report settlement process for exempt units.

Based on this, we believe that our recommendations are valid and should be pursued by HCFA.

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INTRODUCTION

BACKGROUND

Effective October 1, 1983, the Prospective Payment System (PPS) replaced Medicare's cost reimbursement method of paying short-term acute care hospitals for inpatient services. Under the PPS, participating hospitals are reimbursed based on a diagnosis related group (DRG) weight that the Health Care Financing Administration (HCFA) has established for each illness, multiplied by a predetermined rate for each Medicare discharge. The PPS payment rate for each hospital is computed by combining the hospital specific discharge rate with the average Federal discharge rate, known as the Federal rate. The hospital specific rate represents the estimated average cost per discharge at a particular hospital. It was developed based on hospital cost data reported on fiscal year 1982 (base year) Medicare cost reports. The Federal rates were developed by HCFA and were based on hospital cost data reported on fiscal year 1981 (base year) Medicare cost reports. The Federal rates represent the combined estimated average cost per discharge of all hospitals nationwide. This report is concerned with HCFA's inclusion of the cost of hospital units that would be certified as exempt units in computing the average costs per discharge for PPS purposes.

The initial implementation of PPS called for a three year transition period in which the hospital specific portion of the rate was to be eventually phased out, so that in fiscal year 1987, PPS reimbursement would be based entirely on a Federal rate. As originally intended during the transition period, the Federal portion of the blended rate was to be phased in at 25 percent increments per year starting in fiscal year 1984. However, recent changes to the PPS legislation 1/ extend the transition period to include a fourth year. The makeup of the blended rate is now as follows:

Fiscal Year	Hospital Specific Percent	Federal Portion Percent
1984	75	25
1985	50	50
1986	50	50
1987	25	75
1988	0	100

Although Medicare reimbursement for most hospitals is now based on PPS, hospitals could exclude certain types or distinct units from

1/ Consolidated Omnibus Budget Reconciliation Act (COBRA) Section 9102

PPS. In this regard, Section 1886(d)(1)(B) of the Social Security Act specifies that the PPS will not apply to psychiatric or rehabilitation distinct units of a hospital if they meet requirements specified in Federal regulations. In addition, Section 1886 (d)(5)(c)(iii) permits similar exemptions for alcohol/detox units. Hospital units that qualify for this exemption will continue to be paid on a reasonable cost basis. During the development of PPS legislation, it was determined that patients being treated for psychiatric, rehabilitation and alcoholic conditions required specialized staff and intensive individualized treatments that are similar to those provided in long-term care specialized facilities treating similar type patients. Consequently, it was concluded that the types of specialized services provided in exempt units would result in hospitals incurring costs significantly different from those incurred in the general care sections of hospitals which are routinely categorized under DRGs. Therefore, hospital psychiatric, rehabilitation and alcoholic units meeting conditions included in HCFA's administrative instructions (HIM 15, section 2803.6) were eligible to qualify for exemption from PPS.

As of June 1985, approximately 980 hospitals had a total of 1,261 such units certified for exemption from PPS. These included 673 psychiatric, 324 rehabilitation and 264 alcoholic units.

SCOPE OF REVIEW

Our review was made in accordance with governmental auditing standards and centered around an analysis of the development of the PPS blended rate. The objective of our review was to determine the extent to which the inclusion of exempt unit costs in the base year costs used to develop the PPS blended rate affected Medicare reimbursements. Specifically, we:

(1) Obtained fiscal year 1984 Medicare cost reports for the 62 hospitals in our review and determined cost per discharge for Medicare patients in exempt versus acute care units.

(2) Obtained Medicare patient hospitalization information to analyze the lengths of stay for exempt versus acute care unit patients.

(3) Obtained fiscal year 1982 base year cost data used in developing the hospital specific portion of the PPS blended rate at the hospitals in our review.

(4) Recomputed the Target Amount Cost Per Discharge for each hospital utilizing actual cost data for fiscal year 1982 and excluding estimated exempt unit costs.

(5) Calculated fiscal year 1984 excessive reimbursements resulting from the inclusion of exempt unit costs in the hospital specific portions of the blended rates for 62 hospitals.

(6) Estimated potential excessive reimbursements identified for fiscal year 1984 (excluding alcoholic units) to the remainder of the transition period in which the hospital specific rate will be used.

(7) Reviewed fiscal year 1981 base year costs used in developing the Federal portion of the blended rate to determine how exempt unit costs were handled by HCFA.

(8) Estimated the potential excessive reimbursements related to the inclusion of exempt unit costs (excluding alcoholic units) in the Federal portion of the PPS for the four year transition period and for the first year when PPS will be based entirely on a Federal rate.

(9) Held a number of discussions with personnel from HCFA, the fiscal intermediaries and various hospitals.

Field work was performed during the period June 1985 through January 1986 and included on-site work at (1) the three Medicare fiscal intermediaries administering the Part A program in Connecticut and (2) various hospitals located in the State of Connecticut. We also obtained Medicare Part A information related to selected hospitals located in the states of Rhode Island, Vermont, California, Washington, Illinois and Pennsylvania.

INCLUSION OF EXEMPT UNIT COST INFLATES PPS PAYMENTS

Our review disclosed that operating costs and the discharges of hospital exempt units were included in the calculation of the hospital specific and Federal portions of the Medicare PPS blended rates. This caused PPS rates to be overstated because the average operating costs per discharge of the exempt hospital units are higher than the average operating costs per discharge of hospital acute care services. Based on our review, we estimate that hospitals participating in PPS will receive excessive reimbursements of over $595 million (See ATTACHMENT III) because of inflated hospital specific rates and another $524 million (See ATTACHMENT IV) because of the inflated Federal rates during the 4 year PPS transition period. If this condition is not corrected, we estimate that the excessive reimbursements will amount to about $268 million (See ATTACHMENT V) in fiscal year 1988; the first year when PPS will be based entirely on a Federal rate. (See ATTACHMENT I for our method of estimating the excessive payments.)

Exempt Unit Costs Included in PPS Rates

HCFA allowed hospitals participating in PPS to separately identify Medicare services provided in psychiatric, rehabilitation and alcoholic units certified for exemption from PPS and to be reimbursed on the basis of reasonable costs. HCFA policy for certifying units for exemption required hospitals to treat these units as separate cost centers and to report the costs separately on the hospitals' Medicare cost reports. We noted that beginning with fiscal year 1984, the first year of PPS, an increasing number of hospitals requested distinct certification for exempt units. By establishing these units, hospitals were able to receive a cost reimbursement for services which have already been included in the PPS rates. Of the 1,261 units, 1,077 were established concurrently with the effective date of the hospitals participation under PPS.

With respect to this situation, our discussions with various HCFA personnel disclosed that HCFA did not require adjustments to the PPS for the units becoming certified as exempt units. Thus, no adjustments were made to either the 1982 base year costs for the hospital specific rate or to the 1981 base year costs used to calculate the Federal portion of the PPS blended rate. HCFA officials further stated that they did not require adjustments because (1) there was very little time available to gather sufficient data to determine the appropriate adjustment prior to the implementation date of PPS and (2) HCFA believed that exempt unit costs would not have a significant effect on the overall payment rates.

Our review of the legislative history of PPS confirms the fact that time constraints for the implementation of PPS were very tight. The Tax Equity and Fiscal Responsibility Act of 1982, signed into law on September 3, 1982, required the Secretary, HHS, to develop a legislative proposal for Medicare payment to hospitals on a prospective basis. On December 27, 1982, the Secretary submitted the HHS proposal in a report to Congress entitled Hospital Prospective Payment for Medicare. This proposal was developed into Title VI of Public Law 98-21 which provided for Medicare payment for hospital inpatient services under a Prospective Payment System. This law was enacted on April 20, 1983, with the effective date for PPS set for hospital fiscal years beginning on or after October 1, 1983.

Congress, recognizing these tight time constraints, directed the Secretary to use the best available data when initially setting the PPS rates and, consequently, precise calculations were impossible. This extremely short period for implementation of a major revision to the Medicare system required rapid auditing of over 5,400 hospital base year costs reports and the establishment of hospital specific rates based on the results of the audits. In the final analysis, the establishment of PPS rates required HCFA and the intermediaries to make numerous estimates of past costs and projections of future trends, many of which have later been shown to be in error. In this regard, the OIG and the U.S. General Accounting Office have previously reported several problems that have resulted in excessive expenditure of Medicare funds under PPS, i.e., the inappropriate inclusion of capital expenditures in PPS rates, excessive allowances for indirect medical education and the use of unaudited cost reports. We believe that the problem with exempt unit costs is equally significant and requires the attention of HCFA so that the full benefits of this major cost containment system will be effective.

Legal Opinion on Recovery of Excessive Payment

We asked the Office of General Counsel (OGC) if the Federal Government has authority to recover the excessive payments made to hospitals, and, if so, for the most appropriate method to effectuate these recoveries. The OGC response advised that there were three theoretical approaches for the recovery of the excessive reimbursements: (1) prospective adjustment to the PPS rates, (2) retroactive adjustment to the PPS rates and (3) adjustments to payments made on a reasonable cost basis for exempt unit services. However, with respect to the first two methods the OGC indicated that the PPS statutes preclude the rebasing of PPS rates or retroactive adjustments to the PPS rates under these circumstances. On the other hand, the third approach seemed possible under current law.

The OGC commented that "...under section 1861(V)(1)(A) HCFA could revise the reasonable cost reimbursement rules of Part 405, Subpart D, permitting prospective adjustments of reasonable cost amounts paid for particular exempt unit services by offsetting excessive PPS payments as a result of the improper inclusion of costs for that service in the PPS rate...In addition, HCFA could also adopt such an approach retroactively...".

Office of Audit Analysis of Excessive Payment Amounts

During the initial stages of our review, we used fiscal year 1984 Medicare cost reports and performed a comparative analysis of the average costs per discharge of exempt unit patients versus the average costs per discharge of hospital acute care patients. We found that the average costs per discharge for exempt unit patients was much greater than for acute care patients. The following schedule shows examples of this situation:

Hospital	Type Of Exempt Unit	Average Costs Per Discharge	
		Exempt Units	Acute Care Units
A	Rehabilitation	$14,953	$4,277
B	Rehabilitation	11,700	3,568
C	Rehabilitation	10,937	5,044
D	Psychiatric	11,382	5,858
E	Psychiatric	6,669	3,809

We determined that the primary reason for these disparities was that the average length of stay in an exempt unit was much greater than in acute care units. For example, in Connecticut, Medicare exempt unit patients had an average length of stay of 19.4 days while the average for acute care unit Medicare patients was 9.0 days. Based on this situation, it was apparent that by including exempt unit costs in the base, the established PPS blended rates per discharge were inflated.

To determine what effect this situation had on the PPS rates, we expanded our review to include 62 hospitals located in 7 States. These hospitals had a total of 75 units certified as exempt from PPS, including 41 psychiatric, 24 rehabilitation, and 10 alcoholic units. Although our selection of hospitals for review was not based on scientific sampling methods, we believe that the wide

range of locations of hospitals, to include the states of California, Connecticut, Illinois, Pennsylvania, Rhode Island, Vermont and Washington provided us with a valid basis upon which to base conclusions applicable to hospitals nationwide. ATTACHMENT I to this report provides a detailed explanation of the method used to estimate the excessive payments to hospitals.

Analysis of Hospital Specific Costs

Our initial analysis of the hospital specific portion of the PPS rates for these hospitals disclosed that, for the most part, by including exempt unit costs in the calculations, the PPS rates were inflated. To illustrate the effect on the PPS rate, we found that at one hospital, by removing psychiatric exempt unit costs from the base year cost pool along with the related number of Medicare psychiatric discharges, the cost per discharge would be reduced by $56 (from $3,141 to $3,085) as follows:

	Base Period Hospital Costs		Number of Medicare Discharges		Cost Per Discharge
Total Costs	$18,344,336	÷	5,841	=	$3,141
Psychiatric Unit Costs	712,198	÷	125	=	5,698
Total Costs Less Psychiatric Unit Costs	$17,632,138	÷	5,716	=	$3,085

Our estimate of the costs per discharge for exempt units was based on actual fiscal year 1984 reimbursements for exempt unit care, adjusted to represent fiscal year 1982 costs. We used 1984 costs, as submitted by the hospital, adjusted to 1982 costs since 1982 cost reports did not separately identify the costs for this unit. Overall, the results of our sample disclosed that the inclusion of the operating costs of 60 exempt units in the base used to develop the hospital specific portion of the blended rate resulted in inflating the hospitals' blended rates and resulted in excessive Medicare reimbursements of about $17 million to these 60 providers during fiscal year 1984 alone. On the other hand, we found that for 15 other exempt units the inclusion of their operating costs in the blended rate calculation resulted in understated Medicare reimbursements of about $900,000 to these providers. The average net overcharge by type of exempt unit was as follows:

	Psychiatric	Rehabilitation	Alcoholic	Total
Net Total Overcharge	$3,671,340	$12,220,020	$192,848	$16,084,208
No. of Exempt Units	÷ 41	÷ 24	÷ 10	XXX
Average Overcharge Per Unit	$ 89,545	$ 509,167	$ 19,285	XXX

As can be seen from the above analysis, alcoholic exempt units were not as significant a problem as the other type of exempt units. In addition, our analysis disclosed that five of the ten alcoholic units actually caused undercharges to the hospital and the average was further distorted by the fact that one hospital had an overcharge of about $220,000. Based on these factors, we made a decision to eliminate alcoholic exempt units from any further estimates of the results of our review.

We used the results of the remaining 65 psychiatric and rehabilitation units located in 52 hospitals as the basis for estimating potential excessive reimbursements to the Medicare program. The psychiatric and rehabilitation exempt units in our sample received excessive reimbursements of about $15.9 million during fiscal year 1984 (See ATTACHMENT II). Based on these results, we estimate that for the four year PPS transition period, the excessive Medicare reimbursements for the hospital specific portion of the PPS rate will amount to about $595 million nationwide (See ATTACHMENT III).

Analysis of the Federal Portion of the PPS Rate

A similar analysis was done for the Federal portion of the PPS rate. As noted previously, the Federal portion is being phased in and represented 25 percent of the total payment rate in fiscal year 1984. By fiscal year 1988, the PPS rate will be totally based on the Federal national average cost per discharge. From our limited analysis of the hospitals, we have concluded that psychiatric and rehabilitation exempt unit costs were not removed from the base year calculations of the Federal portion and, consequently, this portion of the rate is also overstated. Overstatement of the Federal portion creates an even more widespread problem because this part of the PPS rate is applied to all hospital discharges from the more than 5,400 hospitals covered under PPS and not just those hospitals with exempt units.

By including exempt unit costs in the Federal rate development, we estimate that reimbursements to the more than 5,400 PPS hospitals nationwide will result in additional excessive Medicare reimbursements of about $524 million during the four year transitional period (See ATTACHMENT IV). Beginning in fiscal year 1988, when PPS payments are entirely based on the Federal rate, we estimate that excessive Medicare reimbursement will be about $268 million annually (See ATTACHMENT V).

Recommendations

Considering the significant amounts of Federal funds being unnecessarily expended because of the exempt unit problem as well as the other various PPS areas previously brought to HCFA's attention, we believe that the need to pursue the idea of rebasing the PPS rates should be of paramount importance. The OGC in its response to our request for a legal opinion indicated that under present legislative authority rebasing is prohibited. Therefore, we recommended that HCFA initiate a legislative change to rebase PPS rates concurrent with the use of a 100 percent Federal rate in October 1987. Pending action to rebase, we also recommend that HCFA consider the information in this report in establishing the level of increase in PPS rates during their annual update of the rates.

With respect to the excessive payments identified during our review, we have excluded from our recommendations recovery of excessive payments related to the Federal portion of the PPS rate. In this regard, only about 1,000 of the 5,400 hospitals covered by PPS have exempt units. Therefore, only these hospitals are required to submit separate cost reports for their exempt units which would be subject to settlement on the reasonable cost basis. As pointed out previously, the OGC has ruled that offsets to reasonable costs is the only feasible method of recovery of excessive payments under the current PPS legislative statutes. Thus, the remaining 4,400 hospitals would be able to retain the excessive payments resulting from the inflated Federal portion of the PPS rate. We believe this creates an inequity to be borne only by those hospitals with exempt units and, consequently, we are not proposing recoveries of the excessive reimbursements associated with the Federal portion of the rate.

However, relative to the excessive payments related to the hospital specific rate, we recommend that HCFA revise the reasonable cost reimbursement principles to permit recovery of PPS overpayments by adjusting the reasonable cost payments during the settlement process of future exempt unit cost reports. In this regard, the recommended adjustments are limited to overpayments associated with the inflated hospital specific portion of the PPS rates in effect during the PPS transition period (October 1983 -

September 1987). Precedence for such retroactive recapture provisions is included in Federal regulations at 42 CFR, paragraph 405.415(d)(3). We estimate the excessive reimbursements to be about $197.6 million for fiscal year 1984, $159 million in each of the fiscal years 1985 and 1986, and $79.5 million for fiscal year 1987.

HCFA Comments

With respect to our recommendation to rebase PPS rates, HCFA has responded to the OIG Office of Audit previously. The most recent response was in a memorandum dated September 9, 1986 in response to Audit Control Number 09-62021. In that response, HCFA indicated that the issue of rebasing has been the subject of several studies, but no final decision has been made on rebasing or updating PPS rates. In response to this report, HCFA stated that the OIG exempt unit report was supportive of their decision to freeze payment levels for fiscal year 1986.

Further, HCFA indicated that it recognized that the inclusion of exempt unit costs could potentially distort the rates, however, because of time constraints and cost reporting data limitations there was no reasonable alternative but to use the best data available. Further, HCFA did not agree with our method of estimating the effect by deflating 1984 costs to approximate 1982 costs. HCFA believes that between 1982 and 1984, hospitals incurred costs significantly above the inflation factors in order to meet HCFA's exempt hospital unit standards.

With respect to our recommendations that HCFA recover PPS excessive payments during the settlement process for future exempt unit cost reports, HCFA responded that they question the strength of the legal basis for this suggestion (see APPENDIX).

Office of Audit Response to HCFA Comments

During the course of our review, we held a number of discussions with various Connecticut hospital personnel as well as intermediary provider audit personnel in Connecticut and Pennsylvania. These personnel indicated that it has been their experience that hospitals did not require much in the way of modification of existing psychiatric and rehabilitation units to meet HCFA criteria to qualify for exempt status. Further, we obtained actual fiscal year 1982 cost data for the psychiatric units of two Connecticut hospitals, the only hospitals included in our review that had such data. Our analysis of this data disclosed that these units had increases in costs from 1982 to 1984 that approximated HCFA's inflation factors. Based on these discussions and analyses, we have concluded that hospitals did not incur significant costs in their first year of PPS to meet the criteria

for exempt unit status. Consequently, we are confident that our method of inverting the HCFA inflation factors to arrive at 1982 base year exempt unit costs provides an equitable means of estimating these costs.

With respect to HCFA's comments regarding our recommendation for recovery of the PPS excessive payments, we were advised, as noted in our report, by the OGC that there appeared to be a legal basis to permit recovery of the excessive payments. Based on the above, we believe that our recommendation to recover the excessive payments related to the overstated hospital specific rates in effect during the PPS transition period is valid and should be pursued by HCFA.

Method of Estimating Excessive Payments

The following discussion provides a detailed example of the method used to calculate the excessive payments made to hospitals due to the inclusion of exempt unit costs in the PPS base year cost pools used to determine the hospital specific portion of the PPS blended payment rate. This method was used consistently for all 52 hospitals and 65 exempt units included in our review and formed the basis of all of our estimates of excessive payments. For illustration purposes, we have selected the exempt psychiatric unit of one of these hospitals as an example of our method.

Step # 1

As noted in our report, actual exempt unit costs for fiscal year 1982, the base year for determining the hospital specific portion of the PPS payment rate, were not available or identifiable. Consequently, we had to estimate the amount of exempt unit costs included in the base year cost pool. In this regard, we noted that in the development of the PPS blended rates HCFA applied inflation factors to the base year costs in order to make the 1982 costs comparable to fiscal year 1984 actual costs of hospital operations. During our review, we also noted that fiscal year 1984 was the first year that the hospitals, included in our sample, had reported their exempt unit costs separately from total Medicare costs of operations. We used the 1984 costs as our starting point and adjusted the costs by inverting HCFA's standard inflation factors to arrive at the estimated 1982 costs of operating the exempt units. We believe that this method provides a reasonably accurate estimate of 1982 exempt unit costs. (See page 3 of this Attachment for a more detailed explanation of how we arrived at this conclusion.) The following illustrates this calculation:

Calculation of Estimated FY 1982 Exempt Unit Costs

Actual Psychiatric Exempt Unit Costs for FY 1984		$ 935,546
Actual # of Psychiatric Exempt Unit Discharges for FY 1984	÷	145
FY 1984 Average Cost Per Discharge for Psychiatric Exempt Unit Patient		$ 6,452.05
Inflation Factor (Difference in Costs FY 1982-1984)	÷	113.242%
Estimated FY 1982 Cost Per Discharge Psychiatric Exempt Unit		$ 5,697.58
Actual # of FY 1982 Psychiatric Discharges	X	125
Estimated FY 1982 Cost of Operating Psychiatric Unit		$ 712,198

Step # 2

Using the estimated 1982 costs of operating the exempt unit, we recalculated the PPS Target Amount Per Discharge, or the hospital's fiscal year 1982 average cost per discharge. This was done by backing out the estimated costs and associated number of discharges from the fiscal year 1982 total Medicare inpatient hospital operating costs as reported on the hospital's fiscal year 1982 Medicare cost report. The following illustrates this calculation:

Recalculation of Target Amount Per Discharge

	As Stated	Less Estimated Exempt Unit Cost	Revised Per OIG/OA
Medicare Inpatient Hospital Operating Costs (1)	$18,344,336	$712,198	$17,632,138
Medicare Discharges	÷ 5,841	125	÷ 5,716
Base Period Cost Per Discharge	$ 3,140.62		$ 3,084.70
Case Mix Index (2)	÷ 1.0958		÷ 1.0958
Adjusted Base Year Cost Per Discharge	$ 2,866.05		$ 2,815.03
Inflation Factor - % Increase (3)	X 113.242%		X 113.242%
Average Target Amount Per Discharge for PPS	$ 3,245.57		$ 3,187.80

(1) Represents actual costs for FY 1982, the base year for hospital specific rate calculation. Data was derived from HCFA form 1007.

(2) Adjustment factor calculated for each hospital reflecting the relative costliness of the hospital's mix of patient cases compared to the national average case mix.

(3) Represents inflation factors used by HCFA applied to FY 1982 base year costs to equate FY 1984 costs.

Step # 3

We recalculated the PPS blended payment rate for this hospital. The Target Amount Per Discharge represents the basis for the hospital specific portion of the rate. For fiscal year 1984, the hospital specific portion was 75 percent of the blended rate. The revised blended payment rate was determined as follows:

Recalculation of PPS Blended Payment Rate

Hospital Specific Portion	$3,187.80	X	75%	=	$2,390.85
Federal Portion	3,123.65	X	25%	=	780.91
Revised PPS Blended Payment Rate					$3,171.76

Step # 4

We calculated the amount of excessive PPS payments to the hospital in fiscal year 1984. The following illustrates this calculation:

Calculation of Excessive Payments

	As Stated	Revised Per OIG/OA	Difference
PPS Blended Rate	$ 3,215.09	$ 3,171.76	$ 43.33
# of FY 1984 PPS Discharges	X 6,201	X 6,201	
Subtotal	$19,936,773	$19,668,084	$ 268,689
FY 1984 Case Mix Index	X 1.1558	X 1.1558	
Total PPS Payment	$23,042,922	$22,732,371	$ 310,551

The net result of our calculations for all 52 hospitals and 65 exempt units included in our sample amounted to excessive payments of about $15.9 million for fiscal year 1984. ATTACHMENT II summarizes the results by state.

With respect to our use of fiscal year 1984 exempt unit costs as the basis of our estimates, we determined from discussions with various Connecticut hospital personnel and intermediary provider audit personnel in Connecticut and Pennsylvania that it has been their experience that hospitals did not require much in the way of modification of existing psychiatric and rehabilitation units to meet HCFA criteria to qualify for exempt status. For the most part, the hospitals had such units in existence prior to the start of PPS and, especially with regard to psychiatric units, they were usually contained in separate wings of the hospital. Thus, we believe that the hospitals did not incur significant costs in their first year of PPS to meet the criteria for exempt status. Consequently, we are confident that our method of inverting the HCFA inflation factors provides an equitable means of estimating 1982 base year exempt unit costs.

To further validate our use of 1984 cost data, we were able to obtain actual fiscal year 1982 operating costs for the psychiatric units at two Connecticut hospitals, the only hospitals included in our review that had such data. Our analysis disclosed that these

units had increases in costs from 1982 to 1984 of 7.4 and 14.9 percent, respectively. These increases compare favorably to the 13.242 percent inflation factor used by HCFA to arrive at the PPS payment rate for the same period. An additional comparison of the actual 1982 costs and our estimate of 1982 costs for these two hospitals disclosed that our method actually understated the 1982 psychiatric units cost by about 5 percent for one hospital and overstated the cost by about 1.5 percent for the other hospital. Based on these analyses, we believe that our methodology for estimating base year exempt unit costs is reasonable.

Utilizing the results obtained from our sample hospitals, we estimated the impact of the inflated hospital specific rates for all hospitals with exempt units nationwide. To do this, we categorized the 65 exempt units according to type of unit, i.e., psychiatric or rehabilitation, and determined the average excessive payment per unit for fiscal year 1984. These averages were $119,393 for psychiatric units and $678,889 for rehabilitation units. We applied the averages to the number of units certified for exemption during fiscal year 1984 and took 75 percent of this amount, the percentage applicable to the hospital specific portion of the PPS rate during fiscal year 1984.

For fiscal year 1985, we adjusted the number of exempt units to reflect additional units certified as exempt from PPS during fiscal year 1985. We also made an adjustment to the average excessive payment amount to account for an increase in the 1984 PPS payment rate allowed by HCFA to provide for inflation of hospital operating costs in fiscal year 1985. We then took 50 percent of this amount, the percentage applicable to the hospital specific portion of the PPS rate during fiscal year 1985. For the remaining two years of the transition period, we used the same computation methodology except for adjusting the applicable hospital specific percentage which varied during the transition period. ATTACHMENT III summarizes the results of these calculations.

We also calculated the estimated excessive payments that we believe will be made to hospitals during the PPS transition period because of the inflated Federal portion of the PPS rate. We used the same methodology as described above, basing the results on the 65 exempt psychiatric and rehabilitation units included in our review. However, for this calculation we based the estimates on fiscal year 1981 costs, the base year for the Federal portion of the PPS rate. The estimated excessive payments are summarized on ATTACHMENT IV.

Finally, we also estimated the excessive payments that will result once the PPS rate is based entirely on a Federal rate in fiscal year 1988. The methodology for this calculation was also the same as previously described and the results are summarized on ATTACHMENT V.

ATTACHMENT II

SUMMARY OF EXCESSIVE PAYMENTS
TO HOSPITALS IN OUR REVIEW DUE TO INFLATED
HOSPITAL SPECIFIC PORTION OF PPS RATE
FOR FISCAL YEAR 1984

State	Number of Hospitals	Exempt Unit Excessive Payments: Psychiatric #	Psychiatric Payments	Rehabilitation #	Rehabilitation Payments	Total Excessive Payments
Connecticut	19	18	$1,647,700	6	$ 1,411,406	$ 3,059,106
Rhode Island	2	1	335,100	1	360,632	695,732
Vermont	2	2	(4,882)	1	55,466	50,584
Washington	5	3	63,372	3	1,872,515	1,935,887
California	5	3	194,785	3	3,452,158	3,646,943
Illinois	2	1	(236,062)	2	1,318,708	1,082,646
Pennsylvania	17	13	1,671,327	8	3,749,135	5,420,462
Totals	52	41	$3,671,340	24	$12,220,020	$15,891,360

ATTACHMENT III

ESTIMATED EXCESSIVE PAYMENTS TO HOSPITALS
NATIONWIDE DUE TO INFLATED
HOSPITAL SPECIFIC PORTION OF THE PPS RATE
FOR THE TRANSITION PERIOD

Type of Unit	Fiscal Year	No. of Exempt Units	Excessive Payments Per Unit	Hospital Specific Percent Applicable	Total Excessive Payments
PSYCH	1984	598	$119,393*	75%	$ 53,547,760
PSYCH	1985	673	126,411	50%	42,537,301
PSYCH	1986	673	126,411	50%	42,537,301
PSYCH	1987	673	126,411	25%	21,268,651
REHAB	1984	283	678,889**	75%	144,094,190
REHAB	1985	324	718,794	50%	116,444,628
REHAB	1986	324	718,794	50%	116,444,628
REHAB	1987	324	718,794	25%	58,222,314
Total Hospital Specific Excessive Payments					$595,096,773

* Represents the average excessive payment per unit for the 41 exempt psychiatric units included in sample.

** Represents the average excessive payment per unit for the 24 exempt rehabilitation units included in sample.

Note: For illustration purposes, we have converted the average excessive payments above to represent 100 percent of the difference between what was reimbursed and what should have been reimbursed, per our calculations. We then applied the appropriate hospital specific percentage for the fiscal year to determine the excessive payments for the period.

ATTACHMENT IV

ESTIMATED EXCESSIVE PAYMENTS TO HOSPITALS
NATIONWIDE DUE TO INFLATED
FEDERAL PORTION OF THE PPS RATE
DURING THE TRANSITION PERIOD

Type of Unit	Fiscal Year	No. of Exempt Units	Average Excessive Payment Per Unit	Federal Percent Applicable	Total Excessive Payments
PSYCH	1984	598	$ 93,290*	25%	$ 13,946,855
PSYCH	1985	673	98,773	50%	33,237,114
PSYCH	1986	673	98,773	50%	33,237,114
PSYCH	1987	673	98,773	75%	49,855,671
REHAB	1984	283	586,049**	25%	41,462,966
REHAB	1985	324	620,496	50%	100,520,352
REHAB	1986	324	620,496	50%	100,520,352
REHAB	1987	324	620,496	75%	150,780,528
Total Federal Rate Excessive Payment During Transition Period					$523,560,952

* Represents the average excessive payment per unit for the 41 exempt psychiatric units included in sample.

** Represents the average excessive payment per unit for the 24 exempt rehabilitation units included in sample.

Note: For illustration purposes, we have converted the average excessive payments to represent 100 percent of the difference between what was reimbursed and what should have been reimbursed, per our calculations. We then applied the appropriate Federal rate percentage for the fiscal year to determine the excessive payments for the period.

ATTACHMENT V

ESTIMATED EXCESSIVE PAYMENTS TO HOSPITALS
NATIONWIDE DUE TO INFLATED
FEDERAL PORTION OF THE PPS RATES
FOR THE FISCAL YEAR 1988

Fiscal Year	Previous Year Excessive Payments		No. of Exempt Units	Total Excessive Payments
1988	$ 98,773	x	673(1)	$ 66,474,229
1988	620,496	x	324(2)	201,040,704
Total Federal Rate Excessive Payment During FY 1988				$267,514,933

(1) Psychiatric Units

(2) Rehabilitation Units

APPENDIX

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Memorandum

Date JUL 1 1986

From William L. Roper, M.D.
Administrator

Subject Priority Audit Memorandum - Prospective Payments Inflated by Exempt Unit Costs - ACN 01-62017

To The Inspector General
Office of the Secretary

We have reviewed your memorandum discussing overstatement of the prospective payment rates due to the inclusion of costs of excluded units and offer the following comments.

Although the report raises interesting and important points, we do not believe that it offers an adequate basis for specific revisions to the PPS rates. The OIG memorandum did not provide precise details as to the methodology employed to estimate base period costs of excluded units. The report merely states that 1984 costs of excluded units were adjusted for "inflation and other factors to estimate the amount applicable to each hospital's 1982 base year hospital specific rate." We believe changes in the operations of many of these units as they existed in the base period were necessary in order to meet the criteria for exclusion from the prospective payment system. There is some evidence that these changes involved substantial costs in the 1984 period which did not exist in the base year. The estimate assumes the units' cost increases from 1982 to 1984 did not exceed the inflation rate. However, early data on hospital behavior under the rate of increase ceiling indicate that this is not a valid assumption for a substantial portion of excluded units. Finally, the decrease in length of stay in acute care hospitals could mean that patients being transferred to excluded units may be arriving in poorer condition. Consequently, 1984 costs per case in many excluded units represent a more intensive treatment protocol. For all the above reasons, it is unlikely that deflated 1984 costs per case of excluded units are a good proxy for 1982 costs in such facilities.

In developing the policy for determination of the prospective payment rates, HCFA recognized that inclusion of the costs of psychiatric and rehabilitation units could potentially distort the rates if those units were later determined to be exempt. However, given the statutory time limitations and cost reporting data limitations, we believed there was no reasonable alternative. Under the PPS regulations, providers had to request special certification for their excluded units and many were denied such an exclusion. Since it was impossible to determine whether a provider would eventually establish such a unit or request certification for an existing unit, and whether their request would be approved, it was not possible to exclude such costs in the original calculation of the hospital specific or Federal rate. The legislative history makes it clear that both the hospital specific rates and the Federal rates were to be determined using the best data available at the time the rates were set. It is apparent that Congress was prepared to accept the fact that the prospective payment rates might not represent hospital costs with 100 percent accuracy.

Your memorandum proposes that one remedy for the alleged overstatement of the prospective payment rates would be through a reduction of cost based payments to the units at settlement. As discussed below, we seriously question the legal supportability of this suggestion. The statute requires that excluded units be paid their reasonable cost of providing inpatient hospital services. Each unit is treated as a separate entity for cost determination. While there is precedent for using offsets to determine the net cost of particular items of reimbursement under Medicare, such as offsetting investment income against interest expense, we believe the analogy is weak in this instance. Here, the exempt unit is considered to be a distinct provider, while the alleged overpayment is to a separate (though related) entity, i.e., the acute care hospital. Moreover, as discussed above, we question the ability of the OIG to accurately predict the amount of payment. We believe that any attempt to "backdoor" a downward adjustment of the hospital specific rate by reducing the amount of excluded unit costs recognized for payment would surely be contested through the courts, and we believe our likelihood of prevailing is too slim to justify the cost of defending such a suit.

An additional suggestion in the report is that the inclusion of costs related to excluded units be taken into account in the update factor. We believe that once the rates were established, Congress did not intend HCFA to retrospectively evaluate the process. In discussing future updates of the rates, the statute speaks to an evaluation of the adequacy of the rates to meet current hospital needs. Specifically, section 1886(e)(4) directs the Secretary to establish an update factor "which will take into account amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality." The statute directs that development of the update should be based on consideration of changes in the hospital market-basket, hospital productivity, technological advances, quality of care and long-term cost effectiveness. Thus, the ability to consider possible overpayments in the context of future PPS payments is limited. Moreover, we are concerned that adjustments in this context would prove inequitable because they could not appropriately distinguish between facilities that have exempt units and those which do not.

In summary, we find the OIG's report supportive of our decision to freeze the payment levels for fiscal year 1986. However, we believe future update of the payment rates must be based on analysis of the adequacy of current rates. Therefore, we do not believe a specific payment reduction in response to this finding would be permissible or appropriate.

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