Memorandum

Date JAN 29 1993

From Bryan B. Mitchell
Principal Deputy Inspector General

Subject Effect of the Increased Application of the Comparability Provision on Payments by the Medicare Program and Its Beneficiaries (A-05-92-00100)

To

William Toby, Jr.
Acting Administrator
Health Care Financing Administration

The attached final audit report summarizes the results of our analysis of the implementation of the Medicare Part B comparability provision and the impact comparability had on the adjusted historical payment base (AHPB) used to determine payment amounts under Medicare's Physician Fee Schedule (MPFS). The Medicare comparability provision provides that the reasonable charge for a service may not exceed the established charge for non-Medicare policyholders of a carrier for a comparable service under comparable circumstances.

Under the MPFS legislation, the current reasonable charge payment structure was replaced, effective January 1, 1992, with a fee schedule for physician services. In 1992, total physician payments must equal estimated 1991 payments under the reasonable charge system, plus the 1992 update amount. The Health Care Financing Administration (HCFA) predicted 1991 expenditure levels by aging 1989 claims data. The 1989 claims data is known as the AHPB. The statutory definition of the AHPB in section 1848(a)(2)(D) of the Social Security Act (the Act) requires that the old payment rules, including comparability as it was implemented under that system, be taken into account.

The objectives of our review were to (1) analyze the application of the comparability provision to Medicare Part B reasonable charges, (2) determine the effect on Medicare and beneficiary payments for Fee Screen Years (FSY) 1986 and 1990, and (3) determine the impact on physician payments under MPFS.

Our review showed that the Medicare Part B comparability provision was implemented only at selected carriers. The effect of this limited implementation of comparability was higher payments by the Medicare program and its beneficiaries.

This condition will continue under MPFS because the physician payment statute did not require HCFA to consider potential payment reductions that would have been associated with the increased application of the comparability provision. Moreover, higher payments will continue in future years unless adjustments are made to fee schedule payment amounts.

Our audit of 12 high-dollar volume procedures paid by Blue Shield carriers disclosed that the application of the comparability provision to the Medicare Part B reasonable charges would have saved the Medicare program and its beneficiaries $3.9 million for FSY 1986 and $38.0 million for FSY 1990. In a separate analysis of carrier responses to a 1990 HCFA survey for 30 selected procedures, the increased application of comparability would have reduced Medicare and beneficiaries' payments by $25.6 million.

The potential payment reductions associated with the increased application of the comparability provision were significant. Therefore, we are recommending that HCFA consider the savings identified in this report when updating the MPFS conversion factor as part of the Medicare volume performance standard rates of increase. Section 1848(f)(1)(A)(vii) of the Act authorizes the Secretary to consider "such other factors as the Secretary considers appropriate" in the process of establishing the annual rates of increase.

The HCFA disagrees with our findings and recommendation, questions the methodology used to determine the Medicare cost savings presented in our report, and believes that the savings that could ultimately be generated would not be significant. We disagree with HCFA's underlying premise that this is an insignificant issue and doesn't warrant additional action. The estimated savings of $38.0 million are significant and, accordingly, warrant immediate action. We continue to recommend that HCFA consider these savings when updating the MPFS. If HCFA is unable to make this adjustment, then it should seek legislative authority to consider measurements of comparability as part of the Medicare volume performance standard rates of increase.

Please advise us, within 60 days, on actions taken or planned on our recommendations. If you have any questions, please call me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits at (410) 966-7104. Copies of this report are being sent to other interested Department officials.

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

EFFECT OF THE INCREASED APPLICATION OF THE COMPARABILITY PROVISION ON PAYMENTS BY THE MEDICARE PROGRAM AND ITS BENEFICIARIES

JANUARY 1993 A-05-92-00100

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

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This final audit report summarizes the results of our analysis of the implementation of the Medicare Part B comparability provision and the impact comparability had on the adjusted historical payment base (AHPB) used to determine payment amounts under Medicare's Physician Fee Schedule (MPFS). The Medicare comparability provision provides that the reasonable charge for a service may not exceed the established charge for non-Medicare policyholders of a carrier for a comparable service under comparable circumstances.

Under the MPFS legislation, the current reasonable charge system was replaced, effective January 1, 1992, with a fee schedule for physician services. In 1992, total physician payments must equal estimated 1991 payments under the reasonable charge system, plus the 1992 update amount. The Health Care Financing Administration (HCFA) predicted 1991 expenditure levels by aging 1989 claims data. The 1989 claims data is known as the AHPB. The statutory definition of the AHPB in section 1848(a)(2)(D) of the Social Security Act (the Act) requires that the old payment rules, including comparability as it was implemented under that system, be taken into account.

Our review showed that the Medicare Part B comparability provision was implemented only at selected carriers. The effect of this limited implementation of comparability was higher payments by the Medicare program and its beneficiaries. This condition will continue under MPFS because the physician payment statute did not require HCFA to consider potential payment reductions that would have been associated with the increased application of the comparability provision. Moreover, higher payments will continue in future years unless adjustments are made to fee schedule payment amounts.

Our initial audit of 12 high-dollar volume procedures paid by Blue Shield carriers disclosed that the application of the comparability provision to the Medicare Part B reasonable charges during Fee Screen Year (FSY) 1986 would have reduced Medicare and beneficiary payments by approximately $3.1 million and $0.8 million, respectively (see Exhibit A).

During our expanded audit, we estimated that increased reductions in Medicare program and beneficiary payments for FSY 1990 would have amounted to approximately $30.4 million and $7.6 million, respectively (see Exhibit B).

FSY 1990 PAYMENT REDUCTIONS FROM THE INCREASED APPLICATION OF COMPARABILITY

SURVEY	CODES	SAVINGS
OIG	12	$38.0 MILLION
HCFA	30	$25.6 MILLION

Based on our analysis of carrier responses to a 1990 HCFA survey of 30 selected procedures, the increased application of comparability would have reduced Medicare and beneficiaries' payments by $20.5 million and $5.1 million, respectively (see Exhibit C).

The potential payment reductions associated with the increased application of the comparability provision were significant. Therefore, we are recommending that HCFA consider the savings identified in this report when updating the MPFS conversion factor as part of the Medicare volume performance standard rates of increase. Section 1848(f)(1)(A)(vii) of the Act authorizes the Secretary to consider "such other factors as the Secretary considers appropriate" in the process of establishing the annual rates of increase.

The HCFA disagrees with our findings and recommendation, questions the methodology used to determine the Medicare cost savings presented in our report, and believes that the savings that could ultimately be generated would not be significant. The full text of HCFA's comments are presented in their entirety as Appendix F to this report. We disagree with HCFA's underlying premise that this is an insignificant issue and doesn't warrrant additional action. The estimated savings of $38.0 million are significant and, accordingly, warrant immediate action. We continue to recommend that HCFA consider these savings when updating the MPFS. If HCFA is unable to make this adjustment, then it should seek legislative authority to consider measurements of comparability as part of the Medicare volume performance standard rates of increase.

BACKGROUND

Medicare regulations in effect before January 1, 1992, provided that payment under the Supplemental Medical Insurance Program (Part B) for most medical and other health services furnished by physicians, medical groups, laboratories, etc. will be on a "reasonable charge" basis. The regulations further provided the following flexible criteria for determining the reasonable charge for a specific service: (a) the physician's or other person's customary charge for that service, (b) the prevailing charge made for similar services in the locality, or (c) an index of prevailing charges for a historical period. In addition, 42 CFR 405.508 and section 5002 of the Medicare Carriers Manual provided that the reasonable charge for a service may not exceed the established charge for the carrier's own private policyholders or subscribers for a comparable service under comparable circumstances. This so-called "comparability provision" was intended to assure that Medicare payments to physicians and suppliers, for a comparable service and under comparable circumstances, were not higher than payments provided to non-Medicare policyholders and subscribers of the carrier.

The HCFA established additional regulations that affected the determination of reasonable charges, i.e., fee schedules for radiology services and durable medical equipment, base rates for ambulance use, limitations on services considered to be overpriced procedures, and inherent reasonableness reductions. The HCFA believed that these limitations adequately reduced reasonable charges to below the established charge for the policyholders or subscribers of the carrier.

With the implementation of the Omnibus Budget Reconciliation Act (OBRA) of 1989, section 6102, adding section 1848 to the Social Security Act, "Payment for Physicians' Services," the current reasonable charge payment structure was replaced, effective January 1, 1992, with a fee schedule for physician services based on a resource-based relative value scale. Payments under the fee schedule are based on resources required to produce the services.

The general formula for determining payment amounts under the fee schedule is to multiply a relative value for a service by a geographic adjustment factor for a fee schedule area and by a conversion factor. The conversion factor is a single

national value that will apply to all services paid under the fee schedule. The conversion factor must be computed to provide budget-neutral outlays for 1991. The first step is to compute an AHPB for each service in each fee schedule area. Services from July 1, 1989 to June 30, 1990 were used to calculate the AHPB.

Payment for physician services will also change with respect to the comparability provision. Effective with the implementation of section 4118(k) of the OBRA of 1990 (P.L. 101-508), adding section 1848(i)(3) to the Social Security Act, the application of the comparability provision to payments made under the fee schedule will be prohibited. Section 1848(i)(3) provides:

> For physicians' services for which payment under this part is determined under this section...
>
> (A) a carrier may not make any adjustment in the payments amount under section 1842(b)(3)(B) on the basis that the payment amount is higher than the charge applicable, for a comparable service and under comparable circumstances, to the policyholders and subscribers of the carrier...

SCOPE OF AUDIT

Our audit was conducted in accordance with Government Auditing Standards. The objectives of our review were to (1) analyze the application of the comparability provision to Medicare Part B reasonable charges, (2) determine the effect on Medicare and beneficiary payments for FSYs 1986 and 1990, and (3) determine the impact on physician payments under MPFS. The FSY covers the period of January 1 through December 31. To accomplish the objectives stated above, we reviewed the applicable laws, regulations, and HCFA's instructions and guidelines applicable to the implementation of the Medicare comparability provision. We did not perform a detailed review of the HCFA or carrier internal controls.

Our initial review at the Michigan carrier (final report number A-05-86-62015, dated September 8, 1988), covering

FSY 1986, showed that significant savings were achieved through the application of the comparability provision. Our expanded review at Pennsylvania Blue Shield (final report number A-05-87-00063, dated October 3, 1988) determined that savings existed and could be computed at other locations. In that regard, we also evaluated the application of the comparability provision at the Maryland carrier.

To establish the extent of the application of the comparability provision and the effect on Medicare payments at Blue Shield plans nationwide, we randomly sampled 20 of 25 additional Blue Shield plans that were Part B carriers (see Appendix A). We also evaluated the responses to a 1990 survey of Medicare carriers, initiated by HCFA. The basis for our sample evaluation and projection for FSY 1986 and FSY 1990 is presented in Appendix C. The basis for our review and assessment of the responses to the HCFA survey is presented in Appendix D.

The field work for our audit was performed at various carriers nationwide (see Appendix A for listing) and was completed in Fiscal Year 1991.

RESULTS OF AUDIT

Our audit determined that Medicare payments above private business payment levels continued to exist even after the implementation of various limitations to reasonable charges (e.g., comparability, fee schedules, inherent reasonableness, etc.). We believe that future physician payments may be excessive because the physician payment statute did not require HCFA to consider potential payment reductions that would have been associated with the increased application of the comparability provision.

PAYMENT REDUCTIONS FROM 12 PROCEDURES

$38 MILLION SAVINGS IDENTIFIED FROM OIG STUDY OF COMPARABILITY

Our samples of 12 high-dollar volume procedures paid by 23 Blue Shield Medicare carriers determined that 15 carriers applied the comparability provision (see Appendix A). Five of these carriers (Michigan, Pennsylvania, Missouri, Western New York, and Florida) recognized substantial payment

reductions. The identified payment reductions for the 12 procedure codes at the statistically selected carriers (Florida, Missouri, and Western New York) are as follows:

	Recognized Savings	
	FSY 1986	FSY 1990
Florida	--	$ 628,692
Missouri	$ 94,972	56,204
Western New York	938,132	2,538,507
Total	$1,033,104	$3,223,403

For one of the statistically selected carriers (Massachusetts) that did not apply the comparability provision, we identified that the application of comparability would have resulted in potential savings as follows:

	Potential Savings	
	FSY 1986	FSY 1990
Massachusetts	$1,223,716	$4,057,211

We projected the potential savings to our universe of 25 statistically sampled Blue Shield plans and estimated that the increased application of the comparability provision would have resulted in additional reductions in Medicare program payments of $3.1 million for FSY 1986 and $30.4 million for FSY 1990 (see Exhibits A and B). Related reductions by Medicare beneficiaries would have amounted to $0.8 million for FSY 1986 and $7.6 million for FSY 1990. A detailed description of the calculation of potential reductions is presented in Appendix C.

PAYMENT REDUCTIONS FROM 30 PROCEDURES

In April 1990, HCFA sent a questionnaire to 55 Medicare Part B carriers to determine the effect that the application of the comparability provision had on the Medicare program and its beneficiaries. The questionnaire requested that the carriers

$25.6 MILLION SAVINGS IDENTIFIED FROM A HCFA SURVEY OF COMPARABILITY

provide (i) the FSY 1990 prevailing charge or fee schedule amount, (ii) the comparable private insurance payment amount, and (iii) the Calendar Year (CY) 1989 allowed frequency for each of 30 procedure codes described in the survey. The 30 procedure codes represented a judgmental sample of different types of high volume procedures covered by the Medicare program (i.e., ambulance, radiology, surgery, etc.). Out of the 44 responses, 35 contained sufficient charge information to determine the effect of the application of the comparability provision. The HCFA determined that comparability was not consistently applied.

Our analysis of the 35 responses, containing the requested charge and frequency information, identified potential payment reductions at 8 of the 14 carriers not applying comparability. Our analysis of the eight carriers included a comparison of the Medicare prevailing charge and the related private insurance amount provided by each carrier. The differential was multiplied by the related carrier reported frequency to identify our initial estimate of potential payment reductions. The estimated payment reductions were reduced by the portion of the services not paid at the prevailing payment level.

Based on the responses received in connection with HCFA's 1990 survey, we identified potential payment reductions by the Medicare program and its beneficiaries amounting to $20.5 million and $5.1 million, respectively (see Exhibit C).

OTHER REDUCTIONS TO REASONABLE CHARGES

In addition to the comparability provision, other regulations in effect before January 1, 1992, affected the determination of reasonable charges. For example, the following payment limitations were established: fee schedules for radiology services and durable medical equipment, base rates for ambulance use, limitations on services considered to be overpriced procedures, and inherent reasonableness reductions. The HCFA believed that these limitations adequately reduced reasonable charges below the established charge for the non-Medicare policyholders of the carrier.

To address HCFA's position that other regulatory changes enacted to reduce costs of the Medicare program had eliminated the potential reductions associated with the comparability provision, we performed additional analysis in relation to the

12 selected procedures. Our review determined that the prevailing charges for seven procedures were reduced by regulatory changes (i.e., overpriced procedures) in FSY 1990 (66984, 66983, 27130, 52601, 33512, 45378, and 93000) and that one procedure was affected by radiology fee schedules in FSY 1990 (71020). However, our review determined that potential payment reductions applicable to the comparability provision increased from FSY 1986 to FSY 1990 beyond reductions attributed to other HCFA regulations.

CONCLUSIONS AND RECOMMENDATIONS

The Medicare Part B comparability provision was implemented only at selected carriers. The effect was higher payments by the Medicare program and its beneficiaries. This condition will continue under MPFS because the physician payment statute did not require HCFA to consider reductions in base year expenditures that might have occurred under a more effective application of the comparability provision.

The reasonable charge payment structure for physician services was replaced on January 1, 1992 with a fee schedule for physician services. The fee schedule is required to be budget neutral, that is, payment rates must be determined so that outlays under the new system equal the outlays that would have occurred under the old system. In future years, payment amounts will be determined by updating the base year expenditures by an annual update factor.

The potential payment reductions associated with the increased application of the comparability provision were significant. Therefore, we are recommending that HCFA consider the savings identified in this report when updating the MPFS conversion factor as part of the Medicare volume performance standard rates of increase. Section 1848(f)(1)(A)(vii) of the Act authorizes the Secretary to consider "such other factors as the Secretary considers appropriate" in the process of establishing the annual rates of increase.

If HCFA is unable to make this adjustment, then it should seek legislative authority to consider measurements of comparability as part of the Medicare volume performance standard rates of increase.

HCFA COMMENTS

The HCFA disagrees with our findings and recommendation and questions the methodology used to determine that the MPFS expenditure base is too high. The HCFA believes that the Office of Inspector General (OIG) savings estimates are too high and contends that "...if the OIG methodology were appropriate, the recommendation would call for, at most, a 0.1 percent reduction in the MPFS...."

The HCFA response provides that they are concerned about (i) the criteria used for determining when comparability should have applied; (ii) the line of the carrier's private business that was compared to the Medicare fees; and (iii) the estimated savings attributable to comparability include procedure codes that are not covered under the MPFS. The HCFA's general comments recommend that the report include information explaining how OIG determined that "comparable circumstances" existed in the carriers private lines of business. The HCFA also contends that "the discussion of savings from comparability above and beyond other payment changes on page 8 of the report is not clear." The full text of HCFA's comments is presented as Appendix F to this report.

OIG RESPONSE

The methodology used to estimate the FSY 1990 payment reductions is provided in detail in our report and in the supporting exhibits and appendices. The estimated savings of $38.0 million are based on a procedure code by procedure code analysis comparing the carrier's Medicare reasonable charge to the comparable charge for the carrier's own private policy holders and subscribers for a comparable service under comparable circumstances. We identified the comparable charge for the carrier's own private policyholders and subscribers as the amount most frequently approved by the carrier as payment in full. A comparable line of private insurance and a comparable circumstance existed when (i) the carrier's private business insurance used a customary and prevailing charge methodology similar to Medicare and (ii) the majority (more than 50 percent) of the providers (e.g., physicians, medical groups, laboratories, etc.) agreed with the carrier to accept the private insurance payment as payment in full.

The HCFA's comment that several of the procedure codes surveyed are not covered under the MPFS and, therefore, should not be considered in the savings attributable to comparability is misleading and inaccurate. The OIG estimated savings

for FSY 1990 of $38.0 million includes one procedure code (i.e., A2000) that is not covered under the MPFS. If we remove this procedure code from our estimate of total savings the net effect is approximately $0.4 million. However, the consistent application of comparability for procedure codes not covered under the MPFS is even more critical since these procedure codes do not benefit from the reimbursement limitations derived from the MPFS.

With respect to the savings from comparability, "above and beyond" other payment changes (i.e., fee schedules; overpriced procedures; and inherent reasonableness reductions), we found that the "other payment changes" attributable to HCFA's payment policies did not ensure a Medicare reasonable charge that was less than the comparable charge for the carrier's own private policyholders and subscribers. Accordingly, the effective application of the comparability provision would have resulted in significant additional savings to the Medicare program and its beneficiaries. Our estimated amounts were quantified by comparing the appropriate Medicare reasonable charge to the carrier's comparable private insurance payment amount. These savings are included in the OIG estimated savings of $38.0 million.

The HCFA did not provide any details with respect to how it calculated the 0.1 percent reduction in the MPFS. However, we disagree with HCFA's underlying premise that this is insignificant and doesn't warrant additional action. The FSY 1990 estimated savings of $38.0 million are significant and, accordingly, do warrant immediate action by HCFA. We continue to believe that the recommendations contained in this report are valid.

EXHIBITS

EXHIBIT A

PROJECTION OF PAYMENT REDUCTIONS
FSY 1986
(May 1, 1986 through December 31, 1986)

Estimated Universe of Services with Potential Payment Reductions (Exhibit A-1)	(a)	2,752,750
Average Savings per Service (Exhibit A-2)	(b)	$3.00
Total Potential Payment Reductions--All Medicare Payments at Prevailing Fee Screen ((a) x (b))	(c)	$8,258,250
Carrier Experienced Percentage/Medicare Claims Paid at Prevailing Fee Screen	(d)	38%
Projection of Payment Reductions to Universe of Blue Shield Carriers ((c) x (d))		$3,138,135
Beneficiary Portion - Estimated Payment Reductions		$ 784,534

EXHIBIT A-1

ESTIMATED SERVICES WITH POTENTIAL PAYMENT REDUCTIONS*
FSY 1986

Description			Allowed Services**
Sampled Carriers With Identified Payment Reductions			
Western New York		444,925	
Kansas City, Missouri		432,541	
Massachusetts		758,116	
Total	(a)		1,635,582
Remaining Sampled Carriers			
Total			11,737,265
Total Services - Sampled Carriers	(b)		13,372,847
Non-Sampled Carriers in Universe (5)			9,566,735
Total Services for 25 carriers	(d)		22,939,582
Sampled Carrier Services with Payment Reductions to Total Services - Sampled Carriers ((a) / (b)) (1,635,582/13,372,847)	(c)		12%
Estimated Universe of Services with Potential Payment Reductions ((c) x (d))			2,752,750

*Blue Shield carriers included in our statistical sample

**Number of allowed services pertaining to the 12 procedure codes included in our sample

EXHIBIT A-2

AVERAGE SAVINGS PER SERVICE*
FSY 1986

DESCRIPTION	Allowed Services (a)	Identified Program Reductions (b)
Carriers Applying Comparability		
Michigan	1,718,242	$5,684,255
Pennsylvania	261,375	1,120,336
Maryland	287,854	--
Total	2,267,471	$6,804,591

Average Savings per Service ((b) / (a)) $3.00

*Blue Shield carriers included in our judgmental sample

EXHIBIT B

PROJECTION OF PAYMENT REDUCTIONS
FSY 1990
(January 1, 1990 through December 31, 1990)

Estimated Universe of Services with Potential Payment Reductions (Exhibit B-1)	(a)	14,861,872
Average Savings per Service (Exhibit B-2)	(b)	$5.39
Total Potential Payment Reductions--All Medicare Payments at Prevailing Fee Screen ((a) x (b))	(c)	$80,105,490
Carrier Experienced Percentage/Medicare Claims Paid at Prevailing Fee Screen	(d)	38%
Projection of Payment Reductions to Universe of Blue Shield Carriers ((c) x (d))		$30,440,086
Beneficiary Portion - Estimated Payment Reductions		$7,610,022

EXHIBIT B-1

ESTIMATED SERVICES WITH POTENTIAL PAYMENT REDUCTIONS*
FSY 1990

Description			Allowed Services**
Sampled Carriers With Identified Payment Reductions			
Florida		6,265,710	
Western New York		2,130,462	
Kansas City, Missouri		872,202	
Massachusetts		2,005,928	
Total	(a)		11,274,302
Remaining Sampled Carriers			
Total			26,584,145
Totals Services - Sampled Carriers	(b)		37,858,447
Non-Sampled Carriers in Universe (5)			11,681,127
Total Services for 25 Carriers	(d)		49,539,574
Sampled Carrier Services with Payment Reductions to Total Services - Sampled Carriers ((a) / (b)) (11,274,302/37,858,447)	(c)		30%
Estimated Universe of Services with Potential Payment Reductions ((c) x (d))			14,861,872

*Blue Shield carriers included in our statistical sample

**Number of allowed services pertaining to the 12 procedure codes included in our sample

EXHIBIT B-2

AVERAGE SAVINGS PER SERVICE*
FSY 1990

DESCRIPTION	Allowed Services (a)	Identified Program Savings (b)
Carriers Applying Comparability		
Michigan	3,462,797	$48,017,596
Pennsylvania	766,249	--
Maryland	4,674,756	--
Total	8,903,802	$48,017,596

Average Savings per Service ((b) / (a)) $5.39

*Blue Shield carriers included in our judgmental sample

EXHIBIT C

HCFA SURVEY RESULTS

Identified Payment Reductions - Carriers Not Applying Comparability

Travelers - Connecticut	$ 192
Blue Cross & Blue Shield - Massachusetts	3,792,928
Equicor - North Carolina	327,685
Blue Cross & Blue Shield - Minnesota	10,966
Blue Cross & Blue Shield - California	16,200,770
Travelers - Virginia	1,253
Group Health Insurance - New York	160,248
Blue Cross & Blue Shield - Texas	10,192
TOTAL	$ 20,504,234

Beneficiary Portion - Estimated Payment Reductions $ 5,126,059

Directly Identified Payment Reductions - Carriers Applying Comparability

Blue Cross & Blue Shield - Western New York	$ 3,204,879
Blue Shield - Utah	8,206
Empire - New York	6,337,494
Blue Cross & Blue Shield - Maryland	6,131
Blue Cross & Blue Shield - Pennsylvania	12,322,913
Blue Cross & Blue Shield - Michigan	26,615,908
Blue Cross & Blue Shield - Missouri	595,945
Blue Cross & Blue Shield - Alabama	367,979
Washington Physician Services	11,500
TOTAL	$ 49,470,955

Beneficiary Portion - Estimated Payment Reductions $12,367,739

Identified Payment Reductions - Carriers where the Application of Comparability - Undetermined

Blue Cross & Blue Shield - Iowa	$ 80,201
AEtna - Oklahoma	1,005
Equicor - Tennessee	841,319
Blue Cross & Blue Shield - Nebraska	9,412
TOTAL	$ 931,937

Beneficiary Portion - Estimated Payment Reductions $ 232,984

Total Identified Payment Reductions - HCFA Survey $70,907,126

Total Beneficiary Portion - Estimated Payment Reductions $17,726,782

APPENDICES

APPENDIX A

UNIVERSE OF MEDICARE CARRIERS
EXPANDED COMPARABILITY AUDIT

MEDICARE CARRIER	CARRIER NUMBER	APPLY COMPARABILITY
SAMPLE ITEMS		
BC & BS OF ALABAMA	00510	YES
BS OF CALIFORNIA	00542	NO
BC & BS OF COLORADO	00550	YES
BC & BS OF FLORIDA	00590	YES
BC & BS OF ILLINOIS	00621	NO
BC & BS KANSAS	00650	YES
BC & BS LOUISIANA	00528	NO
BC & BS MASSACHUSETTS	00700	NO
BC & BS MINNESOTA	00720	NO
BC & BS KANSAS CITY	00740	YES
BC & BS MONTANA	00751	YES
BC & BS NEBRASKA	00645	YES
BS OF WESTERN NEW YORK	00801	YES
BC & BS NORTH DAKOTA	00820	YES
SEGUROS DE SERVICIO DE SALUD PUERTO RICO	00973	NO
BC & BS RHODE ISLAND	00870	NO
BC & BS SOUTH CAROLINA	00880	YES
BC & BS TEXAS	00900	NO
BC & BS UTAH	00910	YES
WASHINGTON PHYSICIANS SERVICE	00930	YES
UNIVERSE ITEMS NOT IN SAMPLE		
BC & BS ARKANSAS	00520	
BC & BS INDIANA	00630	
BC & BS IOWA	00640	
BC & BS KENTUCKY	00660	
BC & BS EMPIRE	00803	
JUDGMENTAL ITEMS NOT IN SAMPLE		
BC & BS OF MICHIGAN	00710	YES
BC & BS OF MARYLAND	00690	YES
BC & BS OF PENNSYLVANIA	00865	YES

APPENDIX B

PHYSICIANS CURRENT PROCEDURAL TERMINOLOGY (CPT) CODES

Procedure Code	Description
90050	Office, limited, established patient
90040	Office, brief service, established patient
66984	Extracapsular cataract extraction with insertion of intraocular lens prosthesis (one stage procedure) manual or phacoemulsification technique
66983	Intracapsular cataract extraction with insertion of intraocular lens prosthesis (one stage procedure)
71020	Radiologic examination chest, two views, frontal and lateral
27130	Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip replacement)
93000	Electrocardiogram with interpretation and report; routine ECG with at least 12 leads
A2000	Subluxation of spine
52601	Transurethral resection of prostate, including control of postoperative bleeding during hospitalization, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation and internal urethrotomy are included
33512	Coronary artery bypass, autogenous graft (e.g., saphenous vein or internal mammary artery); three coronary grafts
43235	Upper gastrointestinal endoscopy including esophagus, stomach and either the duodenum and or jejunum as appropriate; complex diagnostic
45378	Colonoscopy, fiberoptic, beyond splenic flexure, diagnostic procedure

DETAILED DESCRIPTION OF CALCULATION OF POTENTIAL REDUCTIONS

During our sample survey of Blue Shield carriers, we identified 12 carriers with a condition and cause similar to the 3 initially selected carriers (Michigan, Maryland, and Pennsylvania). Additional review showed that two of the carriers in FSY 1986 and three of the carriers in FSY 1990 recognized significant savings from the application of the comparability provision to the Medicare reasonable charges. The other eight carriers in our sample survey stated that the comparability provision was not applied to the Medicare Part B reasonable charges. Our survey disclosed that one of the eight carriers (Massachusetts) showed significant potential cost savings if the comparability provision was applied to the Medicare Part B reasonable charges. To determine the cost savings available as a result of applying the comparability provision to Medicare Part B reasonable charges, the cost savings identified at the carrier not applying comparability (Massachusetts), and the recognized cost savings at the carriers that did apply comparability (Missouri, New York, and Florida) were projected to the universe of Blue Shield carriers nationwide (excluding Michigan, Maryland, and Pennsylvania).

We divided the total number of allowed services for the 12 procedure codes (identified in the prior audits) for the carriers with savings by the total number of allowed services for all carriers in our statistical sample. The result represented the percentage of total allowed services that have potential cost savings. This percentage was multiplied by the total number of allowed services for all 25 carriers (the universe) to determine the total number of allowed services with potential cost savings.

We then divided the total identified cost savings for the 3 initially selected Blue Shield carriers (Michigan, Maryland, and Pennsylvania) by the total number of allowed services for the same 3 carriers for the 12 procedure codes. The result represented the average dollar savings for each allowed service.

Our calculation of savings compared the prevailing Medicare payment to the payment allowed by the carrier's private business for the selected procedures. The differential was applied to the frequency of payments for that procedure. Since this estimate was based on the prevailing charge always being the lowest charge and, therefore, the reasonable charge level that would be paid, we adjusted the estimate to reflect the percentage of reasonable charges established at the prevailing payment level based on that experience by the Michigan carrier. The initial estimate of

comparability reductions in the Medicare reasonable charges for the universe of Blue Shield carriers amounted to $8.3 million and $80.1 million during FSYs 1986 and 1990, respectively. The schedule amounts presented reflect a reduction to 38 percent expected to be paid at the prevailing payment level.

The average dollar savings for each allowed service was multiplied by the number of allowed services with potential cost savings. The 38 percent prevailing charge percentage was then applied to the total estimated potential cost savings to determine the effect that application of the comparability provision has on the Medicare program for Blue Shield carriers nationwide that are not currently applying the comparability provision. The estimated savings to the Medicare beneficiaries was calculated in a similar manner.

APPENDIX D

DETAILED DESCRIPTION OF CALCULATION OF POTENTIAL COST SAVINGS RELATED TO THE HCFA SURVEY

During our survey of the Blue Shield carriers, the HCFA conducted a survey of all Medicare Part B carriers. The HCFA survey required the carriers to provide (i) the current FSY 1990 prevailing charge or fee schedule amount, (ii) the comparable private side payment amount, and (iii) the CY 1989 allowed frequency for each of the 30 procedure codes described in the survey. The 30 procedure codes represented a judgmental sample of high volume procedures from the different types of services covered by the Medicare program (i.e., ambulance, radiology, surgery, etc.).

We performed an analysis of the HCFA survey responses received from the carriers. Our analysis included a comparison of the prevailing charge and the related comparable private side payment amount provided by each carrier to determine what the cost savings unit (by procedure code) would be if comparability was applied. This cost savings unit was multiplied by the related carrier reported allowed frequency to determine the cost savings for each procedure code. The cost savings for all 30 procedure codes were totalled for those carriers that did not apply the comparability provision. The 38 percent prevailing charge applied percentage was then applied to the total cost savings to determine the effect that application of the comparability provision has on the Medicare program for Blue Shield carriers nationwide that are not currently applying the comparability provision. The estimated savings to the Medicare beneficiaries was calculated in a similar manner.

APPENDIX E

PHYSICIANS CURRENT PROCEDURAL TERMINOLOGY (CPT) CODES
HCFA SURVEY - 1990

Procedure Code	Description
A0010	BLS Ambulance, base rate
A0020	BLS Ambulance, mileage rate (per mile)
E0255	Hospital Bed, Hi-lo, side rails, mattress (rental rate)
E0730	Transcutaneous Electrical Nerve Stimulator, 4 lead (purchase)
E1130	Standard Wheelchair, fixed arms, swing-away footrest (rental rate)
27130	Total Hip Replacement (Orthopedist)
27447	Total Knee Replacement (Orthopedist)
33512	Coronary Artery Bypass, 3 grafts (Thoracic Surgeon)
33513	Coronary Artery Bypass, 4 grafts (Thoracic Surgeon)
47612	Cholecystectomy, with cholangiography (General Surgeon)
50590	Lithotripsy (Urologist)
52601	Transurethral resection of prostate (Urologist)
66984	Cataract Removal, extracapsular w/insertion (Ophthalmologist)
70450	(global) CAT, head or brain w/o contrast (Radiologist)
70470	(global) CAT, head or brain w/o contrast followed by contrast (Radiologist)
70551-26	MRI, brain (Radiologist)
71010	Chest x-ray, single view (Radiologist)
71020	Chest x-ray, 2 view (Radiologist)
80019	Automated chemistry, 19 tests
81000	Urinalysis
82643	Digoxin
82947	Glucose
85022	Blood Count, automated CBX with man. diff.
90050	Office Visit, limited (Internist, Family Practice)
90060	Office Visit, intermediate (Internist, Family Practice)
90250	Subsequent Hospital Care, limited (Internist, Cardiologist)
90260	Subsequent Hospital Care, intermediate (Internist, Cardiologist)
93000	Routine ECG (Internist)
93010	Routine ECG, interpretation and report only (Internist)
93307	Echocardiography (Cardiologist)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

AUG 21 1992

Memorandum

Date

From William Toby, Jr.
Acting Administrator

Subject Office of Inspector General (OIG) Draft Report: The Effect That the Increased Application of the Comparability Provision Would Have on Payment by the Medicare Program and Its Beneficiaries (A-05-91-00097)

To Inspector General
Office of the Secretary

We have reviewed the above-referenced report which provides the Health Care Financing Administration (HCFA) with the results of OIG's review of the application of the comparability provision at selected carriers nationwide.

In reviewing the application of comparability, OIG found that several Medicare carriers were not implementing the provision at a cost to the Medicare program and its beneficiaries of between $25.6 and $38 million for fiscal year 1990.

Section 1848(i)(3) of the Social Security Act prohibits application of comparability under the Medicare Physician Fee Schedule (MPFS). However, because savings from increased application of the comparability provision were not included in the expenditure base from which the initial budget-neutral fee schedule conversion factor was calculated, OIG believes that payments under the MPFS are too high. Therefore, OIG recommends that HCFA consider the savings identified in this report when updating the MPFS conversion factor as part of the Medicare volume performance rate of increase. If HCFA is unable to make this adjustment, then it should seek legislative authority to consider measurements of comparability as part of the Medicare volume performance standard rates of increase.

We disagree with the recommendation. We question the methodology used by OIG to determine that the MPFS expenditure base is too high. If OIG methodology were appropriate, the recommendation would call for, at most, a 0.1 percent reduction in the MPFS. However, because of our concerns about the methodology of the study, we question whether savings of even 0.1 percent could be achieved. OIG indicates that their questionnaire to carriers solicited the "comparable private insurance payment amount," but this key term is not defined. For example, what criteria were used for determining when comparability should have applied? To which line of the carrier's

private business were Medicare fees compared? The result would vary depending on whether the lowest private fee or the fee for the most frequent line of business were used.

We also note that several of the procedure codes surveyed are not covered under the MPFS. For example, none of the alpha-numeric codes or pathology services which OIG surveyed are covered under the MPFS. Additionally, electrocardiogram interpretations are no longer paid separately under the MPFS and payments for these services were not included in our expenditure estimates for determining the conversion factor. Since these codes are not part of the MPFS expenditure base, it would not be appropriate to consider savings attributable to comparability to these codes.

For these reasons, we believe that OIG savings estimates are too high. We do not believe that the report leads to the conclusion that the MPFS expenditure base was too high by as much as 0.1 percent because of the way comparability was applied under the old methodology. Additional comments are attached for your consideration.

Thank you for the opportunity to review and comment on this draft report. Please advise us if you agree with our position on the report's recommendation at your earliest convenience.

Attachment

Comments of the Health Care Financing Administration (HCFA) on Office of Inspector General (OIG) Draft Report: The Effect That Increased Application of the Comparability Provision Would Have on Payments by the Medicare Program and Its Beneficiaries (A-05-91-00097)

General Comments

In the past, carriers were not to recognize as reasonable any charge which exceeded the established charge for their own private policyholders for a comparable service under comparable circumstances. The report does not explain how OIG concluded that "comparable circumstances" existed in the private business lines of the sampled carriers. The report seems to assume that comparable circumstances existed. We recommend that OIG include information in the report explaining how it determined that the requisite "comparable circumstances" existed in the carriers private lines of business.

Estimates of the savings that could have been achieved from more extensive application of comparability need to take into account that other Medicare payment policies may reduce payments for procedures. OIG recognizes this point and indicates that they have adjusted for this factor. However, the discussion of the savings from comparability above and beyond other payment changes on page 8 of the report is not clear.