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Report to Congressional Committees

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# MEDICARE

# Laboratory Fee Schedules Produced Large Beneficiary Savings but No Program Savings





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The Honorable Lloyd Bentsen
Chairman, Committee on Finance
United States Senate

The Honorable Dan Rostenkowski
Chairman, Committee on Ways and Means
House of Representatives

The Honorable John D. Dingell
Chairman, Committee on Energy and Commerce
House of Representatives

This report summarizes the results of our review of the appropriateness and impact of Medicare's fee schedule payment system for clinical diagnostic laboratory services. Our review of this fee schedule payment system for laboratory services provided to Medicare beneficiaries was required by section 2303 of the Deficit Reduction Act of 1984 (Public Law 98-369).

This report contains a recommendation that your Committees take action to prevent adoption of a national fee schedule based on prevailing charges because that would increase Medicare costs.

We are sending copies of this report to the Director, Office of Management and Budget; the Secretary of Health and Human Services; other congressional committees and subcommittees; and other interested parties.

Richard L. Fogel
Assistant Comptroller General

# Executive Summary

## Purpose

The Deficit Reduction Act of 1984 established a fee schedule payment system for Medicare-covered clinical diagnostic laboratory services furnished by physicians, independent laboratories, and hospitals on an outpatient basis. The system's principal goals were to save the Medicare program and its beneficiaries money and to standardize payments for similar services. Initial fee schedules were established, beginning July 1, 1984, on a geographic basis, and a national fee schedule is to go into effect on January 1, 1990.

The act required GAO to evaluate (1) the appropriateness of the fee schedules and their effects on the volume and quality of clinical laboratory services, (2) the potential effects of adopting a national fee schedule, and (3) the potential effects of applying a national schedule to outpatient tests provided by hospitals. To assess the appropriateness of the fee schedule system, GAO looked at its effects on payments, beneficiary access to laboratory services, and quality of services.

## Background

Before the fee schedules, beneficiaries were responsible for the annual part B deductible of $75, and then Medicare paid 80 percent of approved charges. Beneficiaries were responsible for the remaining 20 percent. On unassigned claims—that is, when the supplier had not agreed to accept the Medicare-approved charge as payment in full—beneficiaries were also responsible for any difference between the approved charge and the actual charge. With the fee schedule payment method, Medicare pays 100 percent of the fee schedule amount for assigned claims for clinical laboratory services; beneficiaries pay nothing.

The Medicare-approved charge for a service is the lowest of the actual charge, the supplier's normal charge (customary charge), or an amount sufficient to cover 75 percent of the normal charges for the service in the area (prevailing charge). The act required Medicare carriers to set fee schedule reimbursement rates based on area prevailing charges.

The Consolidated Omnibus Budget Reconciliation Act of 1985 capped the carriers' fee schedule rates. Starting July 1, 1986, the fee rate for each test procedure was limited to 115 percent of the median of all carriers' fee rates. Beginning January 1, 1988, and until the Health Care Financing Administration (HCFA) implements a national schedule, the cap will be 110 percent of the median fee rate.

## Results in Brief

The fee schedules saved beneficiaries substantial amounts of money, increased Medicare costs somewhat, did not affect beneficiary access to

laboratory services, and had no material effect on quality. Thus, the fee schedule system met its objectives, except for saving Medicare money.

GAO estimates that hospitals on average were paid 89 percent of their outpatient laboratory costs during their first cost reporting periods under the fee schedule system. The losses hospitals incurred, and may incur under a national fee schedule, average about 0.6 percent of total Medicare hospital laboratory costs (including inpatient laboratory services).

If a national fee schedule is computed using the same methodology as was used to compute current fee schedules, rates will go up in some carrier areas and down in others, and total Medicare program payments will increase.

# Principal Findings

## Beneficiary Out-of-Pocket Costs Were Reduced

GAO analyzed laboratory service claims data in 14 carrier areas, which collectively accounted for about 45 percent of Medicare clinical diagnostic laboratory services nationwide. Before the fee schedule payment system was implemented, beneficiaries were liable for average coinsurance of $3.84 per claim, and 56 percent of the clinical laboratory service claims were billed on an assigned basis. During the initial fee schedule period (6 months for six carrier areas and 9 months for the other eight), the assignment rate increased to 78 percent.

Beneficiary coinsurance during this period averaged $1.40 per claim—a reduction of $2.44 per claim. Nationwide, beneficiaries may have saved as much as $220 million during the first year of the fee schedules. GAO estimated beneficiaries saved an additional $93 million for laboratory services provided by hospital outpatient departments.

## Medicare Paid About the Same to Independent Laboratories and Physicians

For clinical laboratory services provided by independent laboratories and physicians, GAO estimates that the Medicare program paid about the same during the first year under the fee schedule payment system as it would have paid under the reasonable charge system. (See pp. 22-25.)

There are two primary reasons why Medicare did not realize immediate significant savings from the fee schedules. First, on assigned claims, Medicare now pays 100 percent of the fee schedule rate, rather than the 80 percent it pays on unassigned claims. Second, the fee schedules were computed from the area prevailing rates used in the reasonable charge

system, even though actual payments under the reasonable charge system were often based on lower allowable charge limits. As a result, Medicare pays more for certain tests—especially high-volume tests that had been subject to reimbursement limits—under the fee schedule system than under the reasonable charge system.

## Access to and Quality of Services Were Unaffected

GAO believes that beneficiary access to Medicare-covered clinical laboratory services was not affected by the implementation of fee schedules. The data GAO analyzed showed the continuation of prior trends in the growth of the number of tests performed for Medicare beneficiaries and in the number of certified laboratories. (See pp. 32-33.)

GAO found no evidence that the quality of tests performed in independent and hospital labs materially changed after the fee schedules were implemented. Quality control and laboratory proficiency testing results from before and after implementation are mixed. These data are not precise enough to enable either HCFA or GAO to conclude that any significant change in the quality of such services has occurred. (See pp. 33-35.)

## Hospital Revenues Were Reduced

Medicare payments to hospitals for outpatient and referred patient laboratory services were increased by the fee schedule payment system. (See p. 48.)

Under the cost reimbursement system, beneficiaries usually paid 20 percent of charges for hospital outpatient laboratory services. Medicare paid the difference between what the beneficiaries had paid and the hospital's reasonable costs of providing those services. Because hospital laboratory costs averaged about 66 percent of charges, beneficiaries actually paid about 30 percent of costs and Medicare about 70 percent under the cost reimbursement system. Based on cost and payment information obtained from 583 hospitals in a nationwide sample, hospitals received about 89 percent of their costs of providing outpatient clinical diagnostic laboratory services to Medicare beneficiaries, all from Medicare because beneficiaries no longer share in the cost. As a group, larger hospitals recovered a greater share of costs under the fee schedule system than did the smallest hospitals. (See p. 49.)

Although total payments to hospitals were reduced by the fee schedules, the reductions appear relatively insignificant. The reductions were on average about 0.6 percent of the total cost of operating a hospital laboratory. (See pp. 50-51.)

## Fee Caps Offer Savings

The fee rate caps in the 1985 act either hold constant or reduce all fee rates. Based on 30 high-volume tests in 41 carrier areas, GAO estimates that a 5-percent reduction in average Medicare payments resulted from the 115 percent of median fee rate cap; a 6-percent reduction will result when the 110 percent cap is effective on January 1, 1988. (See app II.)

## National Fee Schedule Could Cost More

Wide variations in fee schedule rates for the same test exist among the carriers. Therefore, a national fee schedule will significantly affect—either up or down—Medicare payments in many carrier areas. (See pp. 40-41.)

Under the Department of Health and Human Services' (HHS) interpretation of current legislation, HCFA would calculate the national fee schedule using the area prevailing charges (which are based on an amount sufficient to cover 75 percent of the normal charges for laboratory services in an area) that carriers used to establish the initial fee schedules. Using this method would result in increased total Medicare payments. GAO does not agree with this interpretation and believes that the Congress removed the prevailing charge requirement in 1986. (See pp. 15 and 43-46.)

Computing a national fee schedule based on a weighted average of the carrier rates as capped by the 110 percent of the median limit would retain the reduction that resulted from the caps. Using such a methodology would not change total Medicare program payments for clinical diagnostic laboratory services, but Medicare payments would decline by up to 10 percent in some carrier areas and increase up to 18 percent in others. (See pp. 44-45 and app II.)

## Recommendation to Congressional Committees

By 1990 a national fee schedule is to be in place. How the fee schedule will be computed is still in doubt. Neither GAO nor HHS believes that the fee schedule should be based on prevailing charges, but HHS believes the law requires it to use this method. GAO recommends that the cognizant congressional committees take action to prevent adoption of a national fee schedule based on prevailing charges.

## Agency Comments

HHS agreed that prevailing charges should not be used to compute national fee schedules. (See app. IV.)

# Contents

## Figures

## Abbreviations

| | |
|---|---|
| COBRA | Consolidated Omnibus Budget Reconcilitation Act of 1985 |
| DEFRA | Deficit Reduction Act of 1984 |
| GAO | General Accounting Office |
| HCFA | Health Care Financing Administration |
| HCPCS | HCFA Common Procedure Coding System |
| HHS | Department of Health and Human Services |
| LCL | lowest charge level |
| OBRA | Omnibus Budget Reconciliation Act of 1986 |

# Introduction

Effective July 1, 1984, Medicare began paying for outpatient clinical diagnostic laboratory services using fee schedules. Before then, independent laboratories and physician office laboratories were paid on a reasonable charge basis. Hospitals were paid for outpatient laboratory services on a reasonable cost basis; that is, hospitals were paid their costs of providing outpatient laboratory services.

The fee schedule payment system was required by section 2303 of the Deficit Reduction Act of 1984 (DEFRA, Public Law 98-369, July 18, 1984). The payment system covers clinical diagnostic laboratory services provided by physicians, independent laboratories, and hospital laboratory services for outpatients and patients referred to the hospital solely for a laboratory test.[1]

DEFRA required us to evaluate (1) the appropriateness of the fee schedule reimbursement system and its effect on the volume and quality of clinical laboratory services available, (2) the potential effect of creating a national fee schedule, and (3) the potential effect of including hospital outpatient clinical laboratory services in such a national fee schedule.

## The Medicare Program

Medicare is a federal program that pays much of the health care costs of eligible persons—almost all persons 65 and older and some disabled persons. Medicare, established by title XVIII of the Social Security Act, became effective on July 1, 1966. The Medicare program is administered by the Health Care Financing Administration (HCFA), a component of the Department of Health and Human Services (HHS).

Part A, Hospital Insurance, is financed primarily by Social Security payroll taxes. It covers inpatient hospital services, posthospital care in skilled nursing facilities, and care provided in patients' homes and by hospices. In calendar year 1986, about 31 million people were covered by part A; benefit payments for all enrollees totaled about $50 billion. Medicare contracts with insurance companies, called intermediaries, to process and pay claims for part A.

Payment for clinical diagnostic laboratory services for hospital inpatients are included in Medicare's prospective payment rates for inpatient

[1]When dealing with outpatients referred by physicians to the hospital for laboratory tests only, the hospital laboratory functions essentially as an independent laboratory. In this report, these patients are called referred patients.

services, and payment for those laboratory services was not affected by adoption of the fee schedule payment system.

Part B, Supplementary Medical Insurance, is a voluntary program financed by enrollee premiums and federal contributions. Part B covers outpatient hospital services, physician services, and many other health services rendered by various types of suppliers. In calendar year 1986, about 30.5 million people were covered by part B; benefit payments totaled about $26 billion.

Medicare's fee schedule payment system covers part B-financed clinical diagnostic laboratory services rendered in (1) hospital laboratories for hospital outpatients and referred patients, (2) physician office laboratories, and (3) independent laboratories.

Medicare contracts with insurance companies, called carriers, to process and pay part B claims. The part A intermediaries also pay part B claims submitted by hospitals and other institutional providers.

Payment for most part B services is based on reasonable charges. After a beneficiary has incurred $75 in covered expenses in a year, Medicare pays 80 percent of the reasonable charges. Normally, the reasonable charge is the lowest of

- the physician's or supplier's billed amount;
- the physician's or supplier's customary charge for the service, that is, the amount normally charged; or
- the prevailing charge for the service, which is set at a level sufficient to cover 75 percent of the customary charges for a service, weighted by volume, in a particular area.

A provision in the Social Security Amendments of 1972 (section 224(a) of Public Law 92-603) permitted HHS to further restrict reasonable charges for medical services, supplies, and equipment that do not vary significantly in quality between suppliers. For such items, the law allows HCFA to limit the reasonable charge to the lowest charge at which the items are widely and consistently available in a locality. In 1979, HHS designated 12 clinical laboratory test procedures as being subject to the lowest charge level (LCL) limits. HCFA instructed the carriers to limit the

reasonable charge for these items to the 25th percentile of billed charges (for the applicable base period).[2]

For hospital outpatient services, including clinical laboratory services, beneficiaries normally were responsible for paying 20 percent of billed charges; that is, normally the hospital's charges were considered "reasonable" for coinsurance determination purposes. Medicare paid the hospital 80 percent of its reasonable costs except that if beneficiary coinsurance payments exceeded 20 percent of hospital costs, Medicare paid only enough to bring total payments to 100 percent of costs.[3]

## DEFRA Provisions and Subsequent Amendments

DEFRA required the establishment of two fee schedules for clinical laboratory services. One covered the services of independent and physician office laboratories and hospital laboratory services provided to referred patients. The second, slightly higher fee schedule was to pay for clinical laboratory services provided by hospitals to their outpatients. DEFRA required that the rates for the first fee schedule be 60 percent of area prevailing charges and that those for the second be 62 percent of area prevailing charges. The 2-percent differential for hospitals was to compensate them for overhead costs presumed higher than those of physicians and independent laboratories.

In addition to requiring these fee schedules, DEFRA:

- Required direct billing to the Medicare program by the entity that performed clinical diagnostic laboratory services. This direct billing provision essentially prohibits physicians from billing for clinical diagnostic laboratory services unless the services are actually performed in their office laboratories. Before DEFRA, it was a common practice for physicians to bill beneficiaries or the Medicare program for laboratory tests that they had purchased from hospital or independent laboratories.

[2]As discussed in chapter 2, the LCL limits and other special reasonable charge limits established by law or regulations were applied to certain laboratory procedures and claims.

[3]For example, if a hospital outpatient department had charged Medicare beneficiaries $1,000,000 for services, the beneficiaries would have paid $200,000. If Medicare determined that the hospital's costs of the services were $900,000, Medicare would pay $700,000 ($900,000 in costs less $200,000 in beneficiary payments), not 80 percent of costs ($720,000).

- Waived the beneficiary's liability for part B's deductible and coinsurance on all clinical diagnostic laboratory services billed to the Medicare program on an assigned basis.[4]
- Required Medicare payments for all clinical diagnostic service claims from independent laboratories to be made on the basis of assignment.

DEFRA specified that, effective July 1, 1987, HCFA would establish a "national" fee schedule. The only geographic differentials permitted in the national fee rates would be for differences in wage rates. The legislation allowed HCFA considerable latitude in determining the geographic basis to be used in setting fee rates from July 1984 through June 1987.

Except for two metropolitan areas that extend into multiple state areas (Washington, D.C., and Kansas City), the initial fee schedules were set for entire state areas, or the entire area served by a carrier within a state. In most instances, state and carrier area boundaries coincide; therefore, most of the initial fee schedules were set for entire states.

DEFRA also contained a sunset provision regarding the inclusion of hospital outpatient clinical laboratory services under the fee schedule payment system. These services were included only for the 3-year period ending July 1, 1987, the date established in DEFRA for implementation of a national fee schedule system. On that date payment for these services was to revert to the cost-based system of reimbursement.

Certain DEFRA provisions have been modified by subsequent legislation. The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA, Public Law 99-272, Apr. 7, 1986) made several changes affecting the fee schedule reimbursement system. Section 9303 of COBRA:

- Changed the required date for implementation of a national fee schedule payment system from July 1, 1987, to January 1, 1988.
- Extended the sunset date for fee schedule payment of hospital outpatient clinical laboratory services from June 30 to December 31, 1987.
- Established national limits on the carrier area fee schedule rates until a national fee schedule system is implemented. For services rendered on or after July 1, 1986, the limits (fee rate caps) were set at 115 percent of

[4]If a physician or supplier accepts assignment of a Medicare claim, he or she agrees to accept Medicare's allowed amount as payment in full, billing the beneficiary only for the applicable part B deductible and coinsurance. On unassigned claims, the beneficiary is also liable for the difference between the actual charge and Medicare's allowed amount. For clinical laboratory services, accepting assignment means that the provider agrees to accept the fee schedule payment, and the beneficiary pays nothing.

the median of all fee schedule rates for each clinical laboratory test procedure. For services rendered on or after January 1, 1988, and continuing until a national fee schedule is implemented, the fee rate caps are to be set at 110 percent of the median fee rates.

- Mandated that all Medicare claims for clinical laboratory services rendered by physicians on or after January 1, 1987, be paid on the basis of assignment.

Additional changes were made by the Omnibus Budget Reconciliation Act of 1986 (OBRA, Public Law 99-509, Oct. 21, 1986). This legislation:

- Deferred implementation of a national fee schedule payment system until January 1, 1990, and required HHS to report to the Congress by April 1, 1988, on the advisability and feasibility of, and metholology for, establishing a national fee schedule.
- Eliminated the sunset provision for fee schedules for clinical diagnostic laboratory services provided by hospital laboratories to outpatients.
- Limited the hospital laboratories eligible for the 2-percent fee schedule rate differential for outpatient clinical laboratory services to "qualified" hospital laboratories. OBRA defined qualified laboratories as those that operate 24 hours a day to serve a hospital emergency room that is available to provide services 24 hours a day, 7 days a week.

## Fee Schedule Computation Methodology

The fee schedule payment system replaced Medicare's reasonable charge reimbursement system for services provided by physician office and independent laboratories and replaced Medicare's reasonable cost reimbursement system for laboratory services provided by hospital outpatient departments. Hospital laboratory services for referred patients theoretically were already reimbursed through the reasonable charge system,[5] and the fee schedule replaced that system, too.

DEFRA required the fee schedule rates for hospitals and independent and physician laboratories to be computed using reasonable charge data maintained by the Medicare carriers. The 75th percentile area prevailing rate computed using the reasonable charge system methodology was the base used by the Medicare carriers to set the first year fee schedule

[5]In practice, some hospitals apparently misclassified such services for referred patients as outpatient services and, therefore, collected from Medicare intermediaries under the reasonable cost reimbursement system.

rates. DEFRA provided for setting fee rates for clinical diagnostic laboratory services provided by hospital laboratories to outpatients at 62 percent of the 75th percentile area prevailing rates. The fee schedule rates for laboratory services provided in physician offices, by independent laboratories, and to hospital-referred patients were set at 60 percent of the 75th percentile area prevailing rates. As required by DEFRA, the fee schedules have been updated each year for inflation.

OBRA removed the reference to the establishment of a national fee schedule from the section dealing with the methodology for computing laboratory fee schedules. It directed HHS to report to the Congress by April 1, 1988, on the advisability and feasibility of establishing a national fee schedule and on the methodology for computing it. Thus, we believe current law does not set forth or require a specific methodology for setting national fee schedule rates. HCFA believes, however, that the methodology set forth in DEFRA still applies to computation of a national fee schedule.

HCFA does not maintain data that capture Medicare payments for clinical laboratory services. Based on the data we gathered during our work (see pp. 16-18 ), we estimate that Medicare payments for services furnished by physicians and independent laboratories in the period July 1, 1984, through June 30, 1985 (the first year of the fee schedule payment system), were about $820 million. Those services furnished by hospitals for outpatients and referred patients during the hospital's first year under the fee schedule payment system were about $470 million.

## Concerns That Led to the Fee Schedule System

Several concerns about Medicare's reasonable charge payment system led to the creation of the fee schedule system. One concern was that the reasonable charge system was inherently inflationary. Physicians and suppliers know in advance that their billing amounts for the current period would be used to set customary and area prevailing allowances for the next period. This reimbursement method provided an incentive for physicians and suppliers to continually raise their charges to increase future customary and area prevailing allowances. The new fee schedule system was seen as a way to check some of the inflationary pressure.

A second concern was that Medicare was paying widely varying rates for the same test procedure performed by different supplier types (physician office, independent laboratory, and hospital laboratory). Questions that arose from this concern were: Are such differentials justified,

and should Medicare pay different amounts for the same service because of the type or specialty of the supplier? A fee schedule payment system, which equalizes payments among supplier types, overcame this concern. A related concern was that the reasonable charge reimbursement system produced widely varying charge limits among carrier areas that could not reasonably be explained by wage rates or other known differentials. The initial fee schedule eliminated variations within fee schedule areas, and when the fee rates are set nationally, geographic variations will be eliminated.

Still another concern was that some physicians purchased laboratory services from independent laboratories at "wholesale" prices and then "marked up" the prices of those services when they billed the beneficiaries or Medicare. In these cases, the physician received a quantity discount from the independent laboratory, but the Medicare program did not share in that discount. The Congress attempted to deal with this problem in section 918 of the Omnibus Reconciliation Act of 1980 (Public Law 96-499, Dec. 5, 1980). The law established limits, related to reasonable charges of independent laboratories, for laboratory services for which physicians billed Medicare but did not state that they personally performed or supervised the test. On claims that did not state who performed the test, Medicare carriers were instructed to limit payment for purchased services to 80 percent of what the carrier estimated the physician paid for purchased laboratory services. HCFA believed that many physicians did not comply with the disclosure requirement, limiting the effectiveness of the section 918 controls. Under the fee schedule, the entity that performs the test generally must bill the Medicare program for its services.

## Objectives, Scope, and Methodology

Our objectives, as specified in section 2303 of DEFRA, were to assess (1) the appropriateness of the fee schedule payment system and its effect on the volume and quality of clinical laboratory services, (2) the potential effect of adopting a national fee schedule, and (3) the potential effect of including clinical diagnostic laboratory services provided by hospitals to their outpatients in a national fee schedule. In evaluating the appropriateness issue, we considered the financial effect the fee schedule has had on beneficiary and Medicare program payments for clinical laboratory services and supplier receipts per unit of service.

We obtained and analyzed

- computer tape files of clinical laboratory service claims from selected Medicare carriers for periods before and after the fee schedule was implemented;
- hospital laboratory cost, charge, and Medicare payment data from a questionnaire we sent to a national sample of 1,130 hospitals;
- statistical data maintained by HCFA pertaining to (1) the results of laboratory inspections and proficiency tests and (2) laboratory certifications and decertifications;
- a computer tape file from HCFA headquarters containing a consolidated list of clinical laboratory fee procedures and rates for all Medicare carriers;
- selected supporting documentation for the carriers' fee rates from HCFA's regional offices and Medicare carriers; and
- studies and reports addressing the issue of quality of laboratory services, trends in quality, and the relative quality of laboratory services rendered in different environments.

We also contacted representatives of (1) HCFA headquarters in Baltimore; (2) the Centers for Disease Control in Atlanta; (3) selected state laboratory inspection and licensing agencies; (4) officials of selected associations that represent hospitals, physicians, independent laboratories, and laboratory equipment manufacturers; and (5) experts in the field of clinical laboratory testing, particularly those with expertise on testing in the physician office environment. These contacts provided information on the development and implementation of the fee schedule payment system, identified relevant issues and concerns, and provided information helpful in assessing the quality of laboratory services, both before and after the fee schedule was implemented.

We analyzed clinical laboratory claims data from the Medicare carriers listed in table 1.1 for both a period before the fee schedule took effect and a comparable fee schedule period.[6]

[6]For all carriers except Aetna, we analyzed claims for the 9-month pre-fee period of October 1, 1983, through June 30, 1984, and for the fee period of October 1, 1984, through June 30, 1985. Because of data availability limitations, our analysis of Aetna claims was limited to calendar year 1984, January through June for the pre-fee period, and July through December for the fee period.

**Table 1.1: Medicare Carriers From Whom Laboratory Claims Data Were Obtained**

| Medicare carrier | States or areas served |
|---|---|
| Aetna Life and Casualty | Alaska, Arizona, Hawaii, New Mexico, Oklahoma, and Oregon |
| Empire Blue Shield | New York City area, except Queens |
| Florida Blue Shield | Florida |
| Michigan Blue Shield | Michigan |
| Pennsylvania Blue Shield | Delaware, Pennsylvania, and the Washington, D.C., metropolitan area. |
| Texas Blue Shield | Texas |
| Transamerica Occidental Life | Southern California |

We selected these carriers judgmentally to include several of the major claims volume carriers and some small and mid-sized state areas, to obtain a reasonable geographic dispersion of areas, and to minimize the number of carriers from which we requested computer tape claim records. We used the claims data to compare the volume and cost of clinical laboratory services covered by Medicare before and after the fee schedule payment system was implemented. Total Medicare part B payments in these 14 carrier areas accounted for about 45 percent of the nationwide part B payments during fiscal year 1985.

To assess the effect fee schedules are having on hospital reimbursements for outpatient and referred patient clinical laboratory services, we collected data from a nationwide sample of hospitals. We used a sample originally developed by HCFA to validate the first-year prospective payment rates for inpatient hospital services. HCFA's sample contained about 1,200 hospitals, but we eliminated hospitals in states where HCFA waived the fee schedule payment system[7] and individual hospitals that had been granted a fee schedule waiver.[8] After these adjustments, our sample contained 1,130 hospitals.

We sent each of the sampled hospitals a questionnaire requesting information on their total laboratory operating costs and charges for their cost reporting periods ended in 1984 and 1985, and their charges and Medicare payments for outpatient and referred patient clinical laboratory services. In total, 583 of the hospitals were able to furnish all the

[7]Hospitals in states that had waivers to Medicare's prospective payment system for inpatient hospital services normally were not paid for outpatient clinical laboratory services on the fee schedule system.

[8]These hospitals are generally those that are paid a fixed, all-inclusive rate per outpatient visit. The rate covers all services provided, including laboratory services.

necessary data. Using an allocation process similar to that used by Medicare intermediaries to apportion hospital costs between programs, we estimated the hospitals' costs of rendering clinical laboratory services. We then compared this cost with the fee schedule payments they received.

We obtained hospital cost report information from HCFA headquarters to validate the data collected through the questionnaires. The deviations we noted between the questionnaire responses and the information we obtained from these supplemental sources were, in our opinion, minor and generally offsetting.

The principal sources of our automated data were Medicare carrier claims processing and payment systems, which are subject to periodic HCFA reviews and examinations. HCFA relies on the data obtained from these systems as evidence of Medicare-covered services and expenditures and to support its management and budgetary decisions. Thus, we did not independently examine the internal and automatic data processing controls for the automated systems from which we obtained data used in our analyses. Except for this limitation, our work, which was done from June 1985 through June 1987, was performed in accordance with generally accepted government auditing standards.

# Initial Physician Office and Independent Laboratory Fee Schedules Saved Medicare Beneficiaries Money but Had Little Effect on Program Costs

Two principal goals of Medicare's clinical laboratory fee schedule payment system were to

- reduce Medicare program costs for laboratory services through lower payment rates and
- reduce beneficiaries' out-of-pocket costs by eliminating their cost sharing for clinical laboratory services.

The second goal was achieved, and we estimate that beneficiary cost sharing on payments to physicians and independent laboratories decreased about $220 million nationwide during the first year of fee schedule operations. As discussed in chapter 3, we believe the fee schedule had no detrimental effect on beneficiaries' access to services.

At the time the Congress was considering DEFRA, the Congressional Budget Office estimated the first year Medicare program savings from the fee schedule would be about $220 million; however, that goal was not achieved. During the first year of fee schedule system payments (July 1, 1984, through June 30, 1985), we estimate that nationally the Medicare program may have paid about 0.4 percent, or $2.3 million, less for clinical laboratory services than it would have paid had the reasonable charge system been retained.

The Medicare program did not achieve any appreciable savings because the reductions in average allowed charges for clinical laboratory services were insufficient to absorb the beneficiaries' coinsurance on assigned claims and still achieve any appreciable program savings. Thus, Medicare paid about the same amount before and after the fee schedules. Fee rates were not set low enough to generate Medicare program savings because the rate-setting methodology contained in DEFRA did not provide for factoring in reasonable charge system limits that were lower than the normal area prevailing rates for many frequently performed clinical laboratory procedures.

Effective July 1, 1986, COBRA set a maximum fee rate on each clinical laboratory procedure at 115 percent of the median of all carriers' rates for the same procedure. Beginning January 1, 1988, and continuing until HCFA implements a national fee schedule, carrier fee rates will be capped at 110 percent of the median fee rates. These controls will reduce total Medicare payments for clinical laboratory services. We estimate that the Medicare program would have saved about $31 million nationwide had the 110-percent cap been in effect during the first year of the fee schedules.

## Beneficiary Out-of-Pocket Costs Were Reduced Under the Fee Schedule

One goal of the laboratory fee schedule program was to reduce beneficiary out-of-pocket costs for laboratory services. The law establishing the fee schedule eliminated the part B deductible and coinsurance requirements for laboratory services for claims on which the supplier accepts assignment. In addition, the law required that payment for clinical laboratory services provided by independent laboratories be based on Medicare assignment. Hospitals had to accept assignment, as they did before the fee schedule program was enacted. Furthermore, HCFA administratively changed Medicare rules to permit physicians to accept assignment on clinical laboratory services even when they did not accept assignment on other services on the same claim. COBRA required payment for all clinical laboratory services provided by physicians as of January 1, 1987, also to be paid on the basis of Medicare assignment.

The net effect of these changes was an increase in the assignment rate for laboratory services and a decrease in beneficiary out-of-pocket costs. For the 14 carrier areas that we analyzed, the assignment rate for clinical laboratory services supplied by independent laboratories and physicians increased from 56 percent in the year before the fee schedule was adopted to 78 percent during the first year of its use. Therefore, beneficiaries incurred no liability for 78 percent of the laboratory claims under the fee schedule system, but they had incurred a liability for every claim previously.[1] Beneficiary liability on the 22 percent of claims unassigned under the fee schedule system could have been greater than under the reasonable charge system because the difference between the billed amount and the amount Medicare paid could have been greater under the fee schedule.

Table 2.1 illustrates for a hypothetical $19.00 clinical laboratory service claim, billed on both an assigned and unassigned basis, what Medicare would pay and what the beneficiary would be liable for, assuming that the reasonable charge system allowed amount was based on the 75th percentile area prevailing rate.

[1]Before the fee schedule payment system was implemented, beneficiaries were liable for the annual part B deductible and 20-percent coinsurance on assigned and unassigned claims, and for the difference between the billed amount and the Medicare-allowed amount on unassigned claims.

**Table 2.1: Example of Changes in Medicare Payments and Beneficiary Liability Resulting From Implementation of the Fee Schedule System**

| | Reasonable charge system | | Fee schedule system | |
|---|---|---|---|---|
| | Assigned | Unassigned | Assigned | Unassigned |
| Area prevailing and fee rate | $15.00 | $15.00 | $9.00 | $9.00 |
| Billed amount | 19.00 | 19.00 | 19.00 | 19.00 |
| Allowed amount | 15.00 | 15.00 | 9.00 | 9.00 |
| Medicare payment | 12.00 | 12.00 | 9.00 | 7.20 |
| Beneficiary liability | 3.00 | 7.00 | None | 11.80 |

For the first year of the fee schedule system, because of the increase in the assignment rate for clinical laboratory service claims, the average beneficiary liability decreased from $3.84 to $1.40 per claim for the 14 carrier areas reviewed. This saved beneficiaries about $99 million in the areas served by these carriers, and projecting this savings nationwide yields estimated nationwide beneficiary savings of about $220 million. The annual beneficiary savings should now be even greater due to the requirement that physicians' claims for clinical laboratory services that they perform beginning January 1, 1987, be paid on the basis of assignment. Beneficiaries also have realized savings for laboratory services provided by hospital outpatient laboratory departments (see ch. 5).

## No Significant Change in Medicare Program Costs From the First Year Fee Schedules

Another goal of the fee schedule payment system was to save the Medicare program money by lowering the Medicare payment rates for clinical laboratory services. The fee schedules did reduce the average payment for many procedures; however, the average payment rates for some frequently performed procedures were only nominally reduced, or increased, under the fee schedules initially implemented because DEFRA eliminated a number of payment limitations that were in effect before the fee schedule. The result was that total Medicare program payments in the first year of the fee schedule system were about the same as they would have been under the reasonable charge system. However, recent congressional action to modify the fee schedules has resulted in reduced Medicare costs.

To estimate the effect of the fee schedule on Medicare costs, we analyzed the payment changes for between 70 and 76 test procedures that accounted for about 90 percent of total payments for clinical laboratory services in the 14 carrier areas. Included in these high-volume test procedures were a maximum of 12 LCL procedures, a maximum of 14 automatable clinical chemistry blood tests, and a maximum of 50 additional procedures for each carrier.

We selected the LCL procedures for analysis because they are a high-volume test group, and as discussed on pages 11 and 12, they were subject to lower than normal allowable charge limits before the fee schedule.

The clinical chemistry procedures consist of panels of blood chemistry tests that can be performed from one blood sample using multichannel automated test equipment. Nineteen or more individual tests can be simultaneously performed on some automated analyzers. When multiple tests are billed, carriers base their payment on the number of total procedures performed rather than on the individual test procedure rates. We selected the chemical panel tests because they are a high-volume group.

We included in our analyses a maximum of 50 other test procedures that were frequently performed in the carriers' areas. As discussed on pages 25 through 27, the chemical panel and other high-volume test procedures analyzed could be subjected to special reasonable charge system charge limits under certain circumstances.

As table 2.2 shows, applying average fee period payment rates to the pre-fee period claims volume for these high-volume test procedures produces Medicare program payments in the 14 carrier areas that are about $5.3 million, or 2.1 percent, more than would have been paid under the reasonable charge system.

**Table 2.2: Comparison of Medicare Payment Amounts Applying Average Reasonable Charge System and Fee Schedule System Payment Rates**

Number of claims and dollars in thousands

| | Pre-fee claims annualized | | Estimated Medicare payments applying | | | |
|---|---|---|---|---|---|---|
| | | | | | Fee schedule changes | |
| Test group | Number | Percent of total clinical lab test claims | Reasonable charge average rates[a] | Fee schedule average rates[a] | Amount | Percent |
| LCLs | 11,751 | 35.1 | $56,495 | $62,907 | $6,412 | + 11.4 |
| Chemical panels | 4,024 | 12.0 | 59,724 | 62,468 | 2,744 | + 4.6 |
| Other high volume | 14,828 | 44.3 | 141,985 | 138,149 | − 3,836 | − 2.7 |
| **Total** | **30,603** | **91.4** | **$258,204** | **$263,524** | **$5,320** | **2.1** |

[a]We computed average Medicare payment rates and total payment amounts by test procedure and summed the results for the test groups. Therefore, the differences shown are not attributable to changes in the test mix between the two periods. We also inflated the reasonable charge system payment amounts by the Medicare economic index of 3.3 percent to adjust for the time period differences.

The fee schedule payment rate changes collectively caused a 2-percent increase in Medicare payments in the 14 carrier areas we reviewed. However, the fee schedule effect varied considerably among the carrier areas, with several areas achieving a significant reduction in Medicare payments; some achieving a nominal reduction; some incurring a slight increase; and one, Florida, incurring a significant increase.[2] Table 2.3 shows the changes by area.

**Table 2.3: Comparison of Medicare Payments in 14 Carrier Areas Applying the Estimated Reasonable Charge System and Fee Rate System Average Payment Rates**

Dollars in thousands

| Carrier | Reasonable charge system | Fee schedule system | Difference | |
|---|---|---|---|---|
| | | | Amount | Percent |
| Alaska | $240 | $196 | −$44 | −18.3 |
| Oklahoma | 6,551 | 5,715 | −837 | −12.8 |
| Oregon | 5,855 | 5,297 | −558 | −9.5 |
| District of Columbia | 11,422 | 10,341 | −1,081 | −9.5 |
| Delaware | 981 | 899 | −82 | −8.4 |
| Texas | 33,450 | 31,644 | −1,806 | −5.4 |
| Hawaii | 2,077 | 1,976 | −101 | −4.9 |
| Michigan | 52,060 | 50,172 | −1,888 | −3.6 |
| Southern California | 43,078 | 42,744 | −334 | −0.8 |
| Empire Blue Shield | 28,271 | 28,254 | −17 | −0.1 |
| Nevada | 1,514 | 1,525 | 11 | 0.7 |
| Arizona | 6,787 | 6,906 | 118 | 1.7 |
| Pennsylvania | 26,712 | 28,101 | 1,389 | 5.2 |
| Florida | 39,203 | 49,754 | 10,550 | 26.9 |
| **Total** | **$258,204** | **$263,524** | **$5,320** | |
| **Average** | | | | **2.1** |
| **Excluding Florida** | **$219,000** | **$213,770** | **−$5,230** | **−2.4** |

Note: Totals may not add due to rounding.

Because the Florida experience varied so significantly from the other 13 carrier areas, we believe these areas may be more representative of the remainder of the country. Removing Florida from the tabulation yields a 2-percent fee schedule system savings rather than the 2-percent loss yielded by all 14 carriers. Assuming the experience of the 13 carriers

[2]Even though Medicare payments under the fee schedule increased significantly in Florida, the fee schedule rates in Florida are not exceptionally high relative to other carriers; rather, Medicare payments under the former reasonable charge system in Florida were relatively low. This indicates that Florida Blue Shield was taking significant advantage of the payment controls that existed in the reasonable charge system.

represents the rest of the nation and adding the Florida experience separately produces a net estimated fee schedule savings of $2.3 million, or 0.4 percent.

Had we assumed that the 14 carrier areas were typical, our nationwide estimate of first year fee schedule experience would have been about $11.8 million more than the replaced reasonable charge system. Because we judgmentally selected the carriers included in our review, neither estimate can be statistically projected. However, considering that the 14 carrier areas include about 45 percent of nationwide Medicare part B payments, and that our estimates range from a 2-percent savings to a 2-percent increase in Medicare program costs, we believe that the fee schedule system did not produce any significant change in Medicare costs. Later in this chapter, we discuss some additional steps the Congress has taken that we believe will produce savings for the Medicare program.

## Why Medicare Program Costs Were Not Substantially Reduced Under the Fee Schedule

The Medicare program did not achieve any appreciable first year fee schedule system savings because Medicare fee schedule rates were set based on the 75th percentile area prevailing rates from the reasonable charge system. However, Medicare payments under that system were frequently based on other, lower reasonable charge limits. In such instances, the fee schedule payment amounts were frequently more than they would have been using the reasonable charge system payment criteria.

DEFRA provided that the fee schedule rate for each procedure be set at 60 percent of the 75th percentile area prevailing charge, weighted by volume. DEFRA further provided for paying assigned claims at 100 percent of the fee schedule rate. Where Medicare payments were previously made based on the 75th percentile area prevailing charges, the fee schedule formula would mathematically produce a program savings of 25 percent (that is, Medicare would pay 60 percent of the 75th percentile area prevailing charge under the fee schedule, which is 25 percent less than the 80 percent of the 75th percentile area prevailing charge, which was the maximum the program paid under the reasonable charge system).

Under the reasonable charge system, the Medicare-allowed charge was the lowest of (1) the billed charge, (2) a supplier's customary charge for a service, or (3) the 75th percentile area prevailing charge for the service. In some instances, additional lower reasonable charge limits

applied to selected claims or selected services. Included in these special charge limits were the LCL limits discussed on pages 11 and 12, section 918 limits applicable to physician-purchased laboratory services (see p. 16), and carrier adjusted area prevailing allowances, under authority of Medicare's "inherent reasonableness" reimbursement principle. Under Medicare law, this principle permitted carriers to establish special reasonable charge levels for services when the levels determined through the normal 75th percentile method were not inherently reasonable.

The LCL limits were applied to 12 clinical laboratory procedures that HCFA determined to be widely and consistently available. For these procedures, HCFA required the carriers to set payment limits based on the 25th percentile of billed charges. When the 75th percentile prevailing charges were computed for these 12 services for use in establishing the fee schedule amount for them, they were on average 34 percent higher than their LCLs. Thus, when the fee schedule rates were set at 60 percent of the 75th percentile, they were often more than what Medicare had been paying for these services.

The following example, using the hemoglobin test, illustrates what happened for many LCL procedures. Aetna's LCL rate for this procedure in Arizona immediately before the fee schedule was $5.00. The 75th percentile area prevailing rate on which the Arizona fee schedule was based was $8.00, producing a fee rate of $4.80 (60 percent of $8.00). Before the fee schedule, Medicare paid 80 percent of the $5.00 LCL rate, or $4.00. Under the fee schedule, Medicare would pay assigned claims at $4.80.

In the Omnibus Reconciliation Act of 1980, the Congress established an allowable charge limit, applicable to laboratory services that physicians purchased from independent laboratories. This limit was the lowest of (1) the physician's billed charge, (2) the amount the physician paid for the service, or (3) the supplying laboratory's customary charge. If the physician failed to indicate who performed a test, carriers were authorized to use as the reasonable charge the carrier's estimate of the lowest charge at which the physician could have purchased the service from an independent laboratory. For example, in Pennsylvania, the 75th percentile area prevailing rate for a platelet count was $11.00, from which Pennsylvania Blue Shield established a fee rate of $6.60. Before the fee schedule, the carrier set the purchased service estimate at $3.00, and paid 80 percent of that amount, or $2.40 on physician-purchased tests. Under the fee schedule, the supplier is paid $6.60.

If information available to the carriers indicated that the 75th percentile rate was not reasonable, the carriers could substitute a more reasonable rate for the normal 75th percentile prevailing rate. Such inherent reasonableness adjustments were potentially applicable to all clinical laboratory test procedures. The following Florida Blue Shield example, using the 19-panel automated clinical chemistry test, illustrates the effect inherent reasonableness adjustments could have on reasonable charge system payments. Florida Blue Shield computed the 75th percentile area prevailing rate for this procedure to be $30.00, but under the inherent reasonableness principle, the carrier adjusted the allowance to $21.00. Medicare paid 80 percent of that amount, or $16.80 per test. Under the fee schedule, Medicare pays 60 percent of the 75th percentile rate ($30.00), or $18.00 per test on assigned claims.

In addition to these special controls, the two remaining normal reasonable charge limits (the billed amount and supplier customary charge) may have been the allowed charge on some claims. Although we could not separately measure the effect that each reasonable charge system allowable charge cap had in limiting Medicare payments under that system, their cumulative effects are reflected in the average amounts allowed per test procedure.

As table 2.4 shows, average amounts allowed in the 14 carrier areas for the high-volume test procedures analyzed were reduced. But, with the increased claim assignment rate and the DEFRA provision of paying assigned claims at 100 percent of the fee rate rather than 80 percent of the allowed charge, the reductions were insufficient to produce any appreciable decrease in Medicare payments.

**Table 2.4: Fee Schedule Period Average Reductions in Allowed Amounts as Compared to Reasonable Charge Allowances Projected to the Fee Period Using Medicare's Economic Index**

| Test group | Average percent change in allowed amounts |
|---|---|
| LCLs | −7.2 |
| Chemical panels | −18.7 |
| Other high volume | −15.8 |
| **Average** | **−14.9** |

## Fee Schedule Caps Will Produce Medicare Savings

Although the $220 million estimated first year fee schedule savings to the Medicare program were not realized, the Congress has taken steps to reduce the fee rates. In COBRA, the Congress directed HCFA to limit the fee schedule rates to no more than 115 percent of the median fee set by carriers for each clinical laboratory procedure, effective July 1, 1986.

The Congress further instructed HCFA to reduce the cap to 110 percent of the median rate beginning January 1, 1988. The fee rate caps do not increase fee rates for any procedures; they either reduce or have no effect on rates.

Our analysis of the high-volume procedures in 14 carrier areas shows that Medicare payments should be reduced about 5.9 percent annually by the 115-percent cap and about 7.3 percent (an additional 1.4 percent) annually when the 110-percent cap is implemented. As table 2.5 shows, the reductions vary significantly among carrier areas.

**Table 2.5: Effect of Applying the 115 and 110 Percent of Median Fee Rate Caps to the High-Volume Procedures of the 14 Medicare Carriers**

Dollars in thousands

| Carrier area | Carrier fee payments | 115-percent capped payments | 110-percent capped payments | Percent change from carrier fee to 115 cap | Percent change from carrier fee to 110 cap |
|---|---|---|---|---|---|
| Alaska | $196 | $148 | $143 | −24.7 | −27.3 |
| Hawaii | 1,976 | 1,671 | 1,614 | −15.4 | −18.3 |
| Texas | 31,644 | 26,900 | 26,045 | −15.0 | −17.7 |
| Southern California | 42,744 | 37,807 | 36,615 | −11.6 | −14.3 |
| Nevada | 1,525 | 1,409 | 1,373 | −7.6 | −10.0 |
| Oregon | 5,297 | 4,886 | 4,817 | −7.8 | −9.1 |
| District of Columbia | 10,341 | 9,608 | 9,447 | −7.1 | −8.6 |
| Oklahoma | 5,715 | 5,446 | 5,269 | −4.7 | −7.8 |
| Delaware | 899 | 847 | 839 | −5.8 | −6.7 |
| Florida | 49,754 | 48,092 | 47,512 | −3.3 | −4.5 |
| Pennsylvania | 28,101 | 27,139 | 26,979 | −3.4 | −4.0 |
| Empire Blue Shield | 28,254 | 27,650 | 27,527 | −2.1 | −2.6 |
| Arizona | 6,906 | 6,836 | 6,790 | −1.0 | −1.7 |
| Michigan | 50,172 | 49,625 | 49,455 | −1.1 | −1.4 |
| **Total** | **$263,524** | **$248,064** | **$244,425** | **−5.9** | **−7.2** |

Note: Totals may not add due to rounding.

Had the 110 percent of the median cap been in effect during the first fee schedule year, we estimate that Medicare would have saved about $13.8 million, or 5.3 percent, in the 14 carrier areas in comparison with the former reasonable charge reimbursement system ($258.2 million from table 2.3 less $244.4 million from table 2.5 equals $13.8 million). Nationally, we estimate the savings would have been about $31 million.

Although the 110-percent cap will reduce Medicare payments, much of the savings will be offset by COBRA's assignment provision. This provision will cause a decrease in beneficiary payments to physicians but an

increase in Medicare payments to them because Medicare pays 80 percent of the fee rate on unassigned claims, but 100 percent on assigned claims. After both the 110-percent cap and the assignment provision are implemented, we estimate that Medicare program payments will be about 1.2 percent less than they would have been had the reasonable charge system been retained.

## Provider Revenues Per Test Declined Under the Fee Schedule

The average combined payments from Medicare and beneficiaries (the amount suppliers actually receive) per clinical laboratory test procedure decreased for both physicians and independent laboratories under the fee schedule reimbursement system. This reduction is the net effect of slightly increased Medicare payments and significantly reduced beneficiary obligations.[3]

We estimate that the average supplier revenue per test declined about 13 percent under the initial fee schedules. We estimate the decline for independent laboratories at about 21 percent and the decline for physicians at about 9 percent. The smaller decline for physicians is because physicians were not required to bill based on assignment during the initial fee period, and thus, they were able to offset Medicare payment decreases for unassigned claims with increased beneficiary payments.

The 115-percent fee rate cap has reduced, and the 110-percent cap will further reduce, average supplier receipts per test procedure. We estimate that when the full effect of the 110 percent of median fee rate cap is imposed on January 1, 1988, it will cause supplier revenue per test to be about 18 percent less than it would have been under the reasonable charge system. Before adjusting for the effect of assignment, we estimate that the fee rate cap will produce average total payment reductions of about 27 percent for independent laboratories and about 14 percent for physicians—in comparison to the replaced reasonable charge system.

The final factor affecting supplier payments for clinical laboratory services is the requirement that claims from physicians be paid on the basis of assignment. While this requirement will cause Medicare payments to

[3]Under the fee schedules, total payments to independent laboratories increased and declined for physicians. The change in total payments is attributable to the combined effects of payment rate changes, total clinical laboratory test volume growth, and proportionately more Medicare program billings by independent laboratories during the fee schedule period. We believe this latter shift is due, at least in part, to direct billings to Medicare for laboratory services that were previously purchased by physicians and billed to Medicare by the physicians or beneficiaries.

increase (by paying all claims at 100 percent of the fee rate), physicians' average total receipts per test will decline because of a significant decline in beneficiary payments. Under assignment, we estimate that physicians will be receiving about 34 percent less per test. Combining this with the 27-percent reduction for independent laboratories, the reduction in supplier payments per test will average about 32 percent.

## Summary

One of the two main goals for the fee schedule payment system, to reduce beneficiaries' out-of-pocket costs for clinical laboratory services, was achieved. We estimate that beneficiary liability for services supplied by independent laboratories and physicians was reduced by about $220 million nationwide in the first year. Future savings will be more because beneficiaries have no liability on assigned claims for clinical laboratory services, and as of January 1, 1987, all such claims must be paid on the basis of assignment.

The second goal of the fee schedule payment system, to save Medicare money, was not achieved immediately. Under the reasonable charge reimbursement system, carriers could adjust payments for laboratory services through the inherent reasonableness principle, LCL limits, or limits on physician purchased services, but the charge levels allowed under those limits were not used in computing the initial fee schedule rates. As a result, the fee schedule rates for many high-volume procedures were higher than Medicare payments under the former reasonable charge system. For many other procedures, the initial fee schedule rates were only nominally lower than the payments under the reasonable charge system. In COBRA, the Congress directed HCFA to cap laboratory payments at 115 percent of the median of all fee schedules effective July 1, 1986, and to lower the cap to 110 percent of the median of the carrier area fee schedules beginning January 1, 1988.

For the 14 carrier areas we reviewed, the 110-percent cap will reduce Medicare payments about 5.3 percent below what they would have been under the reasonable charge system. However, this saving will be largely offset through COBRA's assignment provision, because unassigned claims (which are no longer allowed) were paid at 80 percent of the fee schedule amount. Taken together, we estimate that the 110-percent cap and the assignment provisions will result in a net decrease of about 1.2 percent in Medicare expenses for clinical laboratory services, beginning January 1, 1988.

The combined effect of the higher Medicare payments and lower beneficiary liability reduced laboratory service providers' average revenue per test by about 13 percent during the first year of the fee schedule. When the full effect of the 110 percent of the median fee rate cap and assignment (for all suppliers) are factored in, physicians and independent laboratories will be receiving, on average, about 32 percent less per test than they would have under the reasonable charge payment system for their clinical laboratory services.

## Agency Comments and Our Evaluation

In commenting on a draft of this report, HHS agreed that the fee schedule payment system did not save the Medicare program money. HHS said that a HCFA study showed the fee schedule payment system cost the Medicare program substantially more than the reasonable charge reimbursement system.

We believe our estimate, which was based on procedures that accounted for about 90 percent of total payments for clinical laboratory services in 14 carrier areas, is more accurate than HCFA's. The differences between HCFA's estimate and ours are discussed in more detail in appendix IV.

# Fee Schedule Payment System Did Not Diminish Beneficiary Access to Services and Had No Apparent Effect on Test Quality

The fee schedule payment system has had no measurable adverse effect on beneficiary access to clinical laboratory services. Claim records for the 14 carrier areas we analyzed show that test volume increased during the first year covered by the fee schedule at about the same rate as it had in the 5 years preceding the fee schedule. Further, HCFA's records show a normal rate of growth in the number of Medicare-certified independent laboratories during the first 2 years after implementing the fee schedule payment system.

We were unable to identify any effect that establishing the fee schedules had on the quality of clinical laboratory services provided by independent, hospital, or physician office laboratories. We reached this conclusion with some caution due to the absence of precise measures to directly compare the quality of clinical laboratory services over time.

## Access to Clinical Laboratory Services Was Not Affected by the Fee Schedules

Claim records for the 14 carrier areas we analyzed show that implementing the fee schedule payment system did not reduce beneficiaries' access to clinical laboratory services. More beneficiaries were served and more tests were performed after the fee schedules were implemented than during a comparable prior period.

Total claims volume for the high-volume procedures discussed in chapter 2 increased about 17 percent—from 30.6 million to 35.9 million—during the first fee schedule year. Changes in claims volume were not evenly distributed among the 14 carriers; volume increased in 11 areas and decreased in 3. Some of the shift may have been due to DEFRA's direct billing requirement. Before DEFRA, a physician who purchased services from an out-of-state laboratory could bill the Medicare carrier serving the physician's area for the service, even though the test may have been performed in another carrier's area; under DEFRA, the testing laboratory must bill the carrier serving the area where the test was performed.

Medicare program statistics for 1979-84 show an average annual increase in bills for laboratory services of about 15 percent, ranging from 11 to 18 percent. This 15-percent increase is composed of an average increase in enrolled beneficiaries of about 2 percent and an average increase in bills per enrolled beneficiary of about 13 percent. The 17-percent increase in clinical laboratory service claims recorded during the first fee period is slightly higher than the previous 5-year average billings increase, but it is less than the rate of increase in 2 of the preceding 5 years.

The number of Medicare beneficiaries provided laboratory services increased during the initial fee schedule reimbursement period, further indicating that beneficiary access to services was not diminished by the fee schedule. For the 14 carrier areas we analyzed, the average number of beneficiaries who received clinical laboratory services in each of the two or three quarters[1] before the fee schedule was implemented was 2.3 million. During the initial two to three quarters under the fee schedule, the average rose to 2.7 million, an increase of about 17 percent. The number of part B enrollees increased about 2.2 percent during the first year under the fee schedule payment system compared to the prior year.

## The Number of Certified Independent Laboratories Increased at a Normal Pace After the Fee Schedule Was Implemented

The fee schedules had no apparent effect on the number of Medicare-certified laboratories. Since the implementation of the fee schedule, the number of Medicare-certified laboratories has steadily and gradually increased, as it had before the fee schedule. From the date the fee schedule was implemented until July 1986, the number of Medicare-certified laboratories increased from 3,410 to 4,142. The quarterly increases ranged from 2 to 4 percent during that time, which was comparable to the increases recorded in the previous 8 quarters, as illustrated in figure 3.1.

## Independent and Hospital Laboratory Quality Indicators Show Mixed Results

Summary results of hospital and independent laboratory quality control inspections[2] and proficiency tests[3] show mixed results after implementation of the fee schedule payment system. From those results, we cannot document any trend in the quality of services provided. Further, if any change in laboratory proficiency or quality has occurred or is occurring, we cannot attribute the change to implementation of the fee schedule payment system.

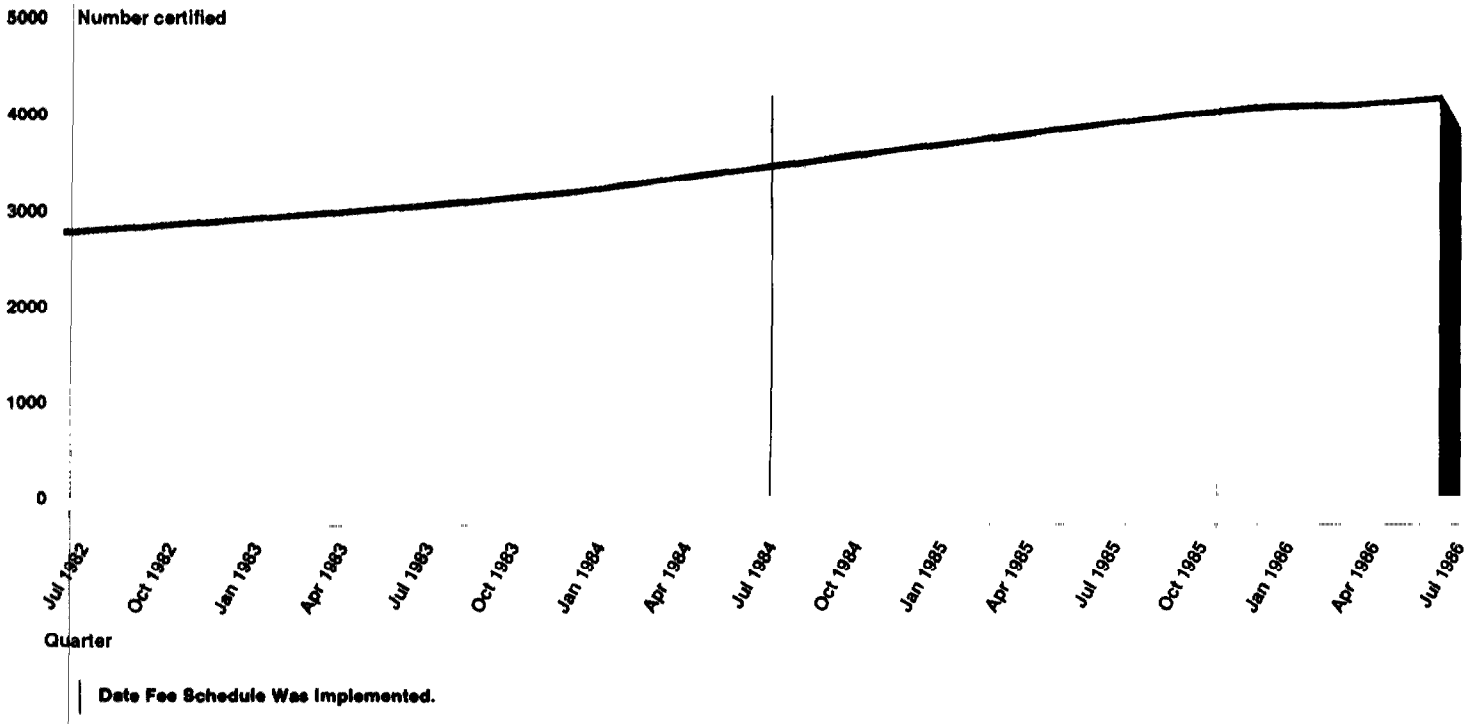
Hospital laboratories and Medicare-certified independent laboratories are subject to similar quality control and proficiency testing standards.

[1]Depending on the amount of data we were able to obtain (see ch. 1).

[2]State agencies or other approved entities perform periodic quality control inspections of independent and hospital laboratories for HCFA. These inspections assess the laboratories' compliance with various Medicare standards concerning compliance with laws, personnel qualifications, management and supervision, laboratory procedures documentation and compliance, and quality control standards and practices.

[3]Independent and hospital laboratories must periodically participate in proficiency tests conducted by any one of several Medicare-approved testing agencies. During these tests, the laboratories analyze test specimens supplied by the testing agency, and their test results are compared with the known test specimen characteristics.

**Figure 3.1: Number of Independent Laboratories Certified for Medicare**




Laboratories of hospitals accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association are inspected and tested by those agencies. HCFA accepts accreditation by those organizations as evidence of meeting Medicare standards for participation. Laboratories of nonaccredited hospitals and independent laboratories are inspected by state inspection agencies for HCFA. As a condition of retaining Medicare certification, hospital and independent laboratories also participate in proficiency testing programs conducted by one of several approved testing organizations.

HCFA collects and maintains statistical data on deficiencies found during the quality control inspections performed by the state agencies. HCFA also collects and maintains proficiency testing results for those same providers and suppliers. The annual inspection and proficiency testing results, expressed as a percentage of standards or test results out of compliance, covering 12-month periods ended June 30, 1982, through June 30, 1986, are summarized in table 3.1. The fee schedule payment

system was in effect during the two most recent periods shown in the table.

**Table 3.1: Annual Quality Control and Proficiency Testing Results for Hospital and Independent Laboratories**

| | Deficiency rates for year ending June 30, | | | | |
|---|---|---|---|---|---|
| | Pre-fee period | | | Fee period | |
| Item | 1982 | 1983 | 1984 | 1985 | 1986 |
| Quality control:[a] | | | | | |
| Hospital | 4.88% | 4.83% | 5.29% | 6.77% | 5.34% |
| Independent labs | 1.35 | 1.33 | 1.81 | 1.78 | 1.61 |
| Proficiency: | | | | | |
| Hospital | 4.16 | 4.72 | 5.49 | 8.09 | 9.20 |
| Independent labs | 5.50 | 5.00 | 4.62 | 5.40 | 7.10 |

[a]Hospital and independent laboratory quality control inspection results are not comparable. Hospital results are summarized for the entire laboratory in one category, but independent laboratory quality control deficiency rates represent the rates of noncompliance with one or more of seven condition categories.

According to HCFA officials, they cannot conclude from the above data that there have been any material changes in the quality of clinical laboratory services since the fee schedule payment system was implemented. The indicators are not precise enough to permit them to draw any conclusions, they said. Further, they stated that other factors, including the implementation of the Medicare hospital prospective payment system for inpatient services, were influencing clinical laboratory services during the same period and that it would not be possible to separate the influence of the fee schedule payment system from other Medicare program changes.

## Physician Office Test Quality Has Historically Lagged Behind That of Independent Laboratories

Physician office laboratories are not subject to quality control inspections or proficiency tests as a condition of Medicare participation. Therefore, the added assurances of quality offered by such inspection and testing programs are lacking for test services performed in physician office laboratories. Additionally, the lack of such programs means that relatively little data are available to assess the quality of tests performed in these laboratories.

Although the lack of data limited our ability to assess any changes that may have occurred in physician office test quality after fee schedule implementation, we have no reason to believe that quality deteriorated. Technological advances, in the form of automated desk-top analyzers developed for physician office use and simpler and easier to use test procedures such as "dip stick" tests, have expanded physician office

test capabilities in recent years. Industry representatives, including some independent laboratory representatives, acknowledge that when properly maintained and operated, these advances offer an opportunity for improved physician office test quality.

The data we obtained (from state inspection activities independent of Medicare, voluntary participation in proficiency testing programs, and special studies) show that the relative quality of laboratory test services performed in physician office laboratories has historically been lower than similar services provided by certified independent laboratories.[4]

The American Association of Bioanalysts, one of the approved laboratory proficiency testing agencies, compared the performance of licensed independent laboratories and physician office laboratories enrolled in their proficiency testing program for 10 common laboratory procedures for a 10-year period. Their analysis showed that the independent laboratories consistently achieved higher proficiency test scores than did physician office laboratories. Table 3.2 shows the relative performance of independent and physician office laboratories for the quarter ended December 31, 1985. We believe this quarter is reasonably typical of the data for the 10-year period.

[4]Some industry representatives believe that although the relative test accuracy differences between physician offices and independent laboratories are statistically significant, they are clinically insignificant. That is, they believe the precision of test results from the office laboratory, when combined with the physician's examination of the patient, is usually sufficient for a physician to make a proper diagnosis.

**Table 3.2: Comparison of Independent Laboratory and Physician Office Laboratory Test Accuracy for Selected Test Procedures**

| Procedures | Coefficient of variation[a] Independent laboratories | Physician office labs | Difference | Percent difference |
|---|---|---|---|---|
| Bilirubin | 12.0% | 17.3% | 5.3% | 44.2% |
| Cholesterol | 12.6 | 15.2 | 2.6 | 20.6 |
| Erythrocytes | 3.0 | 5.3 | 2.3 | 76.7 |
| Glucose | 6.8 | 11.3 | 4.5 | 66.2 |
| Hematocrit | 3.9 | 7.2 | 3.3 | 84.6 |
| Hemoglobin | 2.5 | 4.1 | 1.6 | 64.0 |
| Leukocytes | 5.4 | 10.7 | 5.3 | 98.1 |
| Prothrombin | 9.2 | 10.8 | 1.6 | 17.4 |
| Urea nitrogen | 8.1 | 14.5 | 6.4 | 79.0 |
| Uric acid | 14.9 | 18.6 | 3.7 | 24.8 |
| **Average** | | | | **57.6%** |

[a]The coefficient of variation is a relative measure of dispersion. As used here, it measures the percentage variation of test results from the standard. Smaller variations indicate that test results were concentrated near the standard.

Because the relative quality differences between independent and physician office laboratories' proficiency predates the implementation of the fee schedule payment system, it is obviously not due to the fee schedules. The significance of the relative differences as they relate to the fee schedules is that the fee schedules could have had an indirect effect on quality if they caused a shift in test volume away from the independent laboratories and toward physician office laboratories. As discussed in the following section, our data are inconclusive as to whether such a shift occurred.

## Data Are Inconclusive About Whether Physicians Are Performing Proportionately More Clinical Laboratory Work Under the Fee Schedule Payment System

The claims data from the 14 carrier areas we analyzed are inconclusive as to whether proportionately more clinical laboratory test work was being done in physician offices after implementation of the fee schedule payment system. The cumulative data for the 14 carriers indicate that physician office laboratories may have performed a lower proportion of the total clinical laboratory services immediately after the fee schedule was implemented than before it.

The claims data show that physicians were performing 56 percent of the services before the fee schedule payment system, but 51 percent after. These data must be interpreted with caution, however, because HCFA believed that physicians often did not indicate whether they purchased services before the fee schedules were implemented. A second reason for

caution is that our data do not measure any long-term trends because we have no data for tests after June 30, 1985.

Although data for the 14 carriers in total indicate that physician office laboratories may be performing a smaller proportion of the work, data from three carriers show a significant (13 to 23 percent) increase in the proportion of tests done in physician office laboratories after implementation of the fee schedule. Data from Florida, Nevada, and Arizona indicate that physician office laboratories were collectively performing 48 percent of the work before the fee schedule payment system and 58 percent after. Laboratory service claims from these three carrier areas had the highest proportion of physician-purchased laboratory services during the pre-fee schedule time period among the 14 carriers.

Although the physician office proportion of clinical laboratory testing may have increased in some areas, it is unclear whether there has been any net overall increase in the proportion of such testing.

## Summary

We believe that beneficiary access to Medicare-covered clinical laboratory services was not affected by the implementation of the fee schedule payment system. The data we analyzed showed the continuation of prior trends in the growth of the number of tests performed for Medicare beneficiaries and in the number of certified laboratories.

Also, we found no evidence that the quality of tests performed in independent and hospital labs materially changed after the fee schedule payment system was implemented. The results of quality control and proficiency testing from before and after the implementation of the fee schedule are mixed. These data are not precise enough to enable either HCFA officials or us to conclude that there has been any significant change in the quality of such services.

We cannot tell if the fee schedules have caused a shift in test volume from independent laboratories and to physician office laboratories. Data from 14 carriers we reviewed do not offer evidence of any significant shift during a period immediately following the implementation of the fee schedule. If a shift has occurred or is occurring, it probably is caused by several factors, such as the availability of office testing equipment, and the Medicare fee schedule payment system would only be partially, if at all, responsible.

From a quality perspective, a shift of testing location from the independent laboratory to the physician office would mean that more tests would be performed in an environment that is subject to less stringent quality control standards and proficiency test programs and fewer inspections than independent laboratories. The purpose of those tests and inspections is to help assure accurate test services, and physician office laboratory services are not covered by many of those quality control activities. The data we obtained indicated that the accuracy of tests performed in physician office laboratories has generally been lower than the accuracy of tests performed in independent laboratories, but representatives of testing equipment manufacturers claim that the new technologies being marketed for use in physician office laboratories, if properly used, are very accurate.

# Potential Effects of a National Fee Schedule on Medicare Payments

Current legislation requires HCFA to implement a national fee schedule for clinical laboratory services by January 1, 1990. Regardless of the method HCFA uses to set national fee schedule rates, significant rate changes will occur in some carrier areas because of the widely varying fee rates that currently exist among the carrier areas. Additionally, depending on the methodology applied, total Medicare program payments could be increased or decreased significantly by the national fee schedule.

As we discussed in chapter 2, the initial carrier fee schedule did not achieve its objective of saving Medicare program funds. Some savings are being generated by the fee rate caps established by COBRA, but a significant portion of these savings are being offset by the act's assignment provision. We believe that, as a minimum, the national fee schedule computation methodology HCFA uses should preserve the program savings generated by the caps.

## Carrier-Computed Fee Rates Varied Widely but the Caps in COBRA Narrowed the Range

DEFRA specified that initial fee rates would be set at 60 percent of the 75th percentile area prevailing rates from the replaced reasonable charge reimbursement system. We found that the initial fee rates computed from that base varied widely for the same test procedure among carrier areas. The variation is much greater than can be explained by wage rate variations—the one factor DEFRA permits to be used to make regional adjustments to the national fee schedule.

We selected 30 clinical laboratory test procedures for our analysis of the potential effect of a national fee schedule. The 30 procedures were the highest volume procedures, as measured by Medicare payments, for the 14 carrier areas analyzed (see ch. 2). Collectively, these 30 procedures accounted for more than 60 percent of the total Medicare payments for clinical laboratory test services in the 14 carrier areas.

The average range from lowest to highest carrier fee rate for the 30 selected procedures was 300 percent. The effective range was narrowed considerably by the fee rate caps contained in COBRA. However, after the 110 percent of median fee rate cap is imposed, the average fee rate range for the 30 selected procedures will be 100 percent, which amounts to a reduction in the average range of 67 percent. Table 4.1 shows the uncapped ranges in fee rates for the 30 procedures, and the effect that the 110 percent of the median cap will have (see app. I for a list of the 30 procedures, by procedure code and nomenclature).

**Table 4.1: Ranges of the Fee Rates for 30 Selected Procedures**

| Procedure | Fee schedule rates[a] Lowest | Highest | Range | 110% median cap | Capped fee rate range | Reduction in range |
|---|---|---|---|---|---|---|
| A | $5.30 | $30.00 | 466% | $12.22 | 131% | 72% |
| B | 7.50 | 24.98 | 233 | 15.73 | 110 | 53 |
| C | 9.84 | 28.11 | 186 | 18.54 | 88 | 52 |
| D | 11.20 | 31.20 | 179 | 18.57 | 66 | 63 |
| E | 12.50 | 37.48 | 200 | 19.25 | 54 | 73 |
| F | 3.70 | 7.50 | 103 | 5.50 | 49 | 53 |
| G | 2.10 | 6.20 | 195 | 4.02 | 91 | 53 |
| H | 15.61 | 37.50 | 140 | 21.23 | 36 | 74 |
| I | 7.50 | 29.30 | 291 | 17.16 | 129 | 56 |
| J | 4.40 | 11.20 | 155 | 6.87 | 56 | 64 |
| K | 1.90 | 7.20 | 279 | 5.50 | 189 | 32 |
| L | 5.00 | 10.56 | 111 | 7.26 | 45 | 59 |
| M | 6.90 | 49.19 | 613 | 11.00 | 59 | 90 |
| N | 5.20 | 55.70 | 971 | 10.99 | 111 | 89 |
| O | 16.90 | 49.50 | 193 | 26.84 | 59 | 70 |
| P | 5.00 | 20.00 | 300 | 9.68 | 94 | 69 |
| Q | 4.98 | 21.90 | 340 | 10.34 | 108 | 68 |
| R | 5.60 | 61.80 | 1,004 | 22.00 | 293 | 71 |
| S | 2.20 | 12.50 | 468 | 5.50 | 150 | 68 |
| T | 4.40 | 13.20 | 200 | 8.91 | 103 | 49 |
| U | 6.25 | 16.10 | 158 | 9.57 | 53 | 66 |
| V | 5.00 | 23.10 | 362 | 11.78 | 136 | 63 |
| W | 3.70 | 15.20 | 311 | 10.31 | 179 | 43 |
| X | 4.50 | 9.40 | 109 | 6.88 | 53 | 51 |
| Y | 4.10 | 11.20 | 173 | 6.87 | 68 | 61 |
| Z | 2.80 | 9.40 | 236 | 6.16 | 120 | 49 |
| AA | 15.60 | 49.50 | 217 | 30.25 | 94 | 57 |
| AB | 7.81 | 29.70 | 280 | 13.75 | 76 | 73 |
| AC | 5.60 | 19.50 | 248 | 12.32 | 120 | 52 |
| AD | 6.25 | 24.70 | 295 | 11.00 | 76 | 74 |
| **Average** | | | **300%** | | **100%** | **67%** |

[a]These ranges are based on the 1986 fee year rates. They were increased by 4.1 percent over the 1985 (initial period) rates.

Although the 110 percent of the median cap reduces the effective fee rate variations considerably, significant variations will remain. Because payment rates are not equalized nationally by the fee rate cap, as economic adjustment factors are annually applied to the capped rates, the remaining variability would be magnified over time. For example, if the

fee for a procedure were $5 in one area and $10 in another, a 5-percent increase would raise the fee to $5.25 and $10.50, respectively. Thus, the difference between the fees would increase from $5 to $5.25. For this reason, we do not believe the capped fee rates are a good permanent alternative to a national fee schedule.

To determine whether the variation in carrier-computed fee rates could be rationally explained by wage rate variations, we performed a correlation analysis for 100 frequently performed clinical laboratory procedures. We used hospital average hourly wages as a proxy for laboratory personnel wages. We found a relatively weak correlation for about half of the procedures examined, and essentially no correlation for the other half. Therefore, the wide variations in carrier computed fee rates are not explained by wage rate variations.

## Effect of the Fee Rate Cap on Medicare Payments

In chapter 2, we estimated that the 110 percent of median fee rate cap would reduce program payments by 7.3 percent compared to the uncapped carrier fee rates. To assess the probable effect of the cap on a broader range of carriers, we compared the Medicare payments applying uncapped and capped carrier fee rates for 41 of the 57 carrier areas for the 30 tests included in table 4.1.[1] We estimate that the 110 percent of the median fee rate cap will reduce Medicare payments in these 41 carrier areas by about 6.4 percent. A 5-percent reduction has already been achieved by the 115 percent of the median fee rate cap that went into effect on July 1, 1986.

The reductions in Medicare payments produced by the 110-percent cap range from less than 1 to about 21 percent. The number of carriers in various reduction range groupings are shown in table 4.2 (see app. II for the details on each of the 41 carrier areas).

[1]The 41 carrier areas included in this analysis were carriers that furnished us calendar year 1983 claims volume data with certain fee schedule materials we requested during our review, or for which we had volume data on the claims data tapes we obtained from selected carriers. For some carriers, our analysis was limited to fewer than 30 procedures because we lacked either volume or fee rate data for some procedures. The minimum number of procedures analyzed was 18 and the average was 26.

**Table 4.2: Range of Medicare Payment Reductions Resulting From Imposition of the 110 Percent of the Median Fee Rate Cap in 41 Carrier Areas**

| Reduction range | Number of carriers | Percent of total |
|---|---|---|
| 5 percent or less | 24 | 59 |
| 5.1-10 percent | 10 | 25 |
| 10.1-15 percent | 3 | 7 |
| 15.1-20 percent | 3 | 7 |
| 20 percent or more | 1 | 2 |
| **Total** | **41** | **100** |

A very few carrier areas that have both high volumes of clinical laboratory services and relatively high fee rates contribute the majority of the savings accruing from the 110-percent cap. Of the total savings estimated for the 41 carrier areas, more than 50 percent results from application of the cap in two states—California (both the southern and northern carrier areas) and Texas. Although the cap produces significant reductions in payments in some other states, such as Alaska and Hawaii, they are small volume areas, and thus contribute very little to the total Medicare program savings achieved by the caps.

## A Weighted Average of Carrier-Capped Fee Rates Is a Logical National Fee Schedule Methodology

DEFRA required that the original carrier fee schedule rates be computed from the reasonable charge system volume weighted customary charge data. The original fee schedules were computed from those data, using calendar year 1983 reasonable charge system data for input. Once the initial fee schedule rates were computed, DEFRA provided for succeeding year rates to be updated by applying economic adjustment factors to the prior period rates, and the carriers have made such adjustments using factors supplied by HCFA.

DEFRA required that the national fee schedule be computed using the same methodology as was applied for the original fee schedules, but with national data input. Therefore, HCFA would

- obtain the 1983 volume-weighted reasonable charge data used by each carrier to compute its initial fee rates;
- merge the data nationally to compute national 75th percentile area prevailing rates, from which 60 and 62 percent fee rates can be computed; and
- inflate the data to the current time period by applying appropriate economic factors.

HCFA has previously attempted to obtain from all carriers the volume-weighted customary charge data they used to compute the original carrier fee schedule rates. HCFA had very limited success, obtaining usable data from only about 20 carrier areas. Several other carriers submitted data that HCFA found to contain errors. In addition, some carriers were unable to respond for technical or budgetary reasons.

One technical problem HCFA would encounter even if it obtained the 1983 base data is that it would not be in the current HCFA Common Procedure Coding System (HCPCS) codes. Therefore, procedure coding conversions would be required before HCFA could merge the data into one national data base.

We believe that the original DEFRA intent of computing national fee rates from the reasonable charge system data could be achieved by computing national rates using a volume-weighted average of the current carrier fee rates. Because the original carrier fee rates were computed using the DEFRA-required methodology, we believe that applying a volume-weighted average formula to these rates will produce rates that closely approximate the rates that would be computed if the DEFRA-specified methodology were used.

If the national fee schedule computation method originally required by DEFRA is used, Medicare costs could increase because this method is essentially the same as that used to compute area fee schedules and would probably have the same results as it did then—little change in Medicare costs. To achieve even a limited portion of the original DEFRA objective of saving Medicare program funds, HCFA would have to use a methodology to compute national fee schedule rates that factors in the savings from the caps.

By using carrier fee rates capped by the 110 percent of the median limit, the effect of the COBRA-required cap will be automatically factored in and preserved in the national fee schedule rates. Other advantages of this methodology include

- its use of current time period data (fee rates and claim volume), which are more readily available than 1983 data and should be recorded in the standardized HCPCS procedure codes, and
- its relative ease of computation.

Computing national fee rates by applying a volume-weighted formula to the carrier-capped rates would cause Medicare payments in some carrier

areas to be reduced below the current capped levels, while other areas would recover most or all of the reductions imposed by the caps. In fact, the areas with the greatest reductions in payments caused by the cap would likely be the areas with greater additional reductions from the national averaging, because many of their current fee rates are at the cap (the upper limit).

Without considering wage-rate adjustments, we estimate that the effect on Medicare payments in the 41 carrier areas of a national fee schedule computed using the volume-weighted formula would range from an increase of about 18 percent to a decline of about 10 percent, in comparison with the current capped payments. The numbers of carriers in various range groupings are shown in table 4.3 (see app. II for the details on each of the 41 carrier areas).

**Table 4.3: Range of Medicare Payment Changes Resulting From Applying a Volume-Weighted Average Formula to the Carrier-Capped Fee Rates and Payments**

| Reduction range | Number of carriers | Percent of total |
|---|---|---|
| 5-10% Decrease | 8 | 20 |
| 0-5% Decrease | 13 | 32 |
| 0-5% Increase | 10 | 24 |
| 5-10% Increase | 6 | 15 |
| 10-15% Increase | 1 | 2 |
| 15-20% Increase | 3 | 7 |
| **Total** | **41** | **100** |

## Conclusions

HCFA has not yet decided how it will compute national fee schedule rates for laboratory services. Regardless of the method used, significant rate changes will occur in some carrier areas because of the widely varying fee rates that currently exist among the carrier areas. Additionally, depending on the methodology applied, total Medicare program payments could be increased or decreased by a national fee schedule.

HCFA believes that it must compute a national fee schedule from the reasonable charge system data the carriers used to compute their original fee schedules. Our data show that this would increase Medicare costs. Moreover, because of the changes OBRA made to the DEFRA provision (see p. 15), we believe that HCFA is no longer required to use prevailing charges to compute a national fee schedule.

The fee rate caps are producing nominal Medicare payment declines in many carrier areas and significant declines in a few areas. Overall, the

caps are producing some program savings compared to the reasonable charge system that the fee schedules replaced. This is in line with DEFRA's intent. Therefore, we believe the savings resulting from these payment caps should be "locked in" when computing a national fee schedule.

## Recommendation to Congressional Committees

We recommend that the cognizant congressional committees take action to prevent adoption of a national laboratory fee schedule based on prevailing charges because using that methodology would increase Medicare costs.

## Agency Comments

HHS agreed that prevailing charges should not be used as the basis for a national fee schedule.

# Fee Schedule Payment System Increased Medicare Costs for Hospital Outpatient Laboratory Services

DEFRA changed the reimbursement system for outpatient and referred patient clinical laboratory services provided by hospitals from cost reimbursement to a fee schedule. DEFRA contained a sunset provision that would have returned hospitals to the cost reimbursement system effective July 1, 1987; however, amendments included in OBRA made the fee schedule reimbursement system permanent for hospital outpatient and referred patient clinical laboratory services. One purpose for DEFRA changing the payment system for hospital outpatient and referred patient clinical laboratory services from cost reimbursement to a fee schedule was to achieve equality of payment rates for like services regardless of the entity performing the services.

As a result of the change, the Medicare program is paying on a weighted basis about 32 percent more for these clinical laboratory services, but hospitals are receiving about 11 percent less. The difference is because the beneficiary does not pay coinsurance for clinical laboratory services paid under the fee schedule. Thus, beneficiaries enjoyed a significant savings.

## Beneficiaries Realized Significant Savings

We obtained cost, charge, and payments data from a sample of 583 hospitals nationwide (see app. III for details on the sample selection method, questionnaire response rate, and confidence intervals for estimates). Our sample was stratified based on four regions of the country and four bed-size groups. The financial data for the sampled hospitals showed that under the cost reimbursement system, Medicare beneficiaries would have paid about $30.7 million on clinical laboratory services that cost $91.4 million. Projecting the sample results to hospitals represented by the respondents, we estimate that beneficiary cost sharing was reduced by about $93 million as a result of the change to the fee schedule payment system, because beneficiaries no longer had to pay deductibles or coinsurance for these services.

For part B services, Medicare normally paid 80 percent of the reasonable charge for a service, and beneficiaries paid the remaining 20 percent on assigned claims. Hospitals were required to accept assignment for part B services and were reimbursed their reasonable costs of providing services to Medicare beneficiaries. Those costs were determined on the basis of cost reporting periods and were usually not known at the time services were provided. For part B hospital outpatient services, including clinical laboratory services provided before the fee schedule was implemented, beneficiaries were responsible for 20 percent of the

hospital charges when services were provided. When the provider submitted its cost report and it was reviewed and paid by the fiscal intermediary, Medicare would pay the provider the difference between what the beneficiaries had paid in coinsurance and the provider's reasonable cost of providing the services. For clinical laboratory services, this meant that beneficiaries often paid more than 20 percent of the cost of services from institutional providers because their coinsurance amount was computed at 20 percent of the charges, and for the hospitals in our sample, the cost of clinical laboratory services averaged about 66 percent of charges.

## Medicare Payments Increased in All Four Regions

For the 583 hospitals in our sample, Medicare payments increased $20.5 million (from $60.7 million to $81.2 million), or about 34 percent. Projected to hospitals represented by the respondents to our questionnaire, the increase is about $61 million, or about 32 percent on a weighted basis. Medicare payments increased in all four regions, and for all bed-size groups on a national basis. Table 5.1 shows the percentage change in Medicare program payments as projected for hospitals in each bed-size group and region.

**Table 5.1: Average Percent Increase in Medicare Payments for Outpatient Laboratory Services at Hospitals as a Result of the Fee Schedule Payment System**

| | Percent Increase |
|---|---|
| **Region:** | |
| Northeast | 62 |
| North Central | 20 |
| South | 47 |
| West | 12 |
| **Bed size:** | |
| 1 - 149 | 9 |
| 150 - 299 | 41 |
| 300 - 499 | 48 |
| 500 & more | 31 |
| **Overall average** | **32** |

Although Medicare payments increased in each region and for all bed-size groups, the rate of increase varied considerably among regions and bed-size groups. On a regional basis, Medicare payments to hospitals, on the average, increased from 12 percent in the Western region to 62 percent in the Northeast region. From the bed-size perspective, the payments increased from 9 percent for the smallest group to 48 percent for the 300 to 499 bed-size group.

## Fee Schedule Payments Do Not Cover Hospital Costs of Providing Services

Under the cost reimbursement system, hospitals were generally entitled to payments equaling the reasonable cost of providing the services. On a weighted average basis, under the fee schedules, hospitals are receiving about 11 percent less than full cost reimbursement. However, some hospitals are receiving more than full cost reimbursement under the fee schedule and are making a profit on outpatient laboratory services.

The 583 hospitals in our sample reported that their costs of providing the outpatient laboratory services were $91.4 million. Those same hospitals told us they received fee schedule payments totaling $81.2 million for the 1-year period we analyzed, which is $10.2 million, or 11 percent, less than their costs of providing services. Projecting these results to the hospitals represented by our respondents, we estimate that hospitals received about $31 million, or 11 percent, less under the fee schedule payment system than they would have received under the cost reimbursement system. Our estimates of costs recovered under the fee schedule payment system and the hospital occupancy rates for the average hospital in each region and bed-size group are shown in table 5.2.

**Table 5.2: Hospital Outpatient Laboratory Costs Recovered Under the Fee Schedule Payment System and Hospital Occupancy Rates**

| | Percentage of costs recovered | Occupancy rates |
|---|---|---|
| **Region:** | | |
| Northeast | 100 | 71% |
| North Central | 83 | 53 |
| South | 94 | 58 |
| West | 79 | 51 |
| **Bed size:** | | |
| 1 - 149 | 77 | 40 |
| 150 - 299 | 94 | 60 |
| 300 - 499 | 95 | 68 |
| 500 & more | 87 | 72 |
| **Overall average** | **89** | **57** |

As with the Medicare payments, the change in hospital revenues varied considerably by region and bed-size group. On the average, hospitals in the Northeast made a slight profit, while hospitals in all other regions lost money under the fee schedule, with those in the West losing the most. Viewed by bed size, all groups received payments under the fee schedule that did not cover the costs of providing the services. The greatest losses were at the smallest hospitals. Those hospitals also had the lowest occupancy rates during the period covered by our questionnaire, and thus may not have been able to benefit from the economies of

scale that larger hospitals, which had higher occupancy rates, could. The lower a hospital's occupancy rate, the fewer inpatient laboratory tests it would provide. Because hospitals normally provide more inpatient tests than outpatient tests, low occupancy rates generally would result in fewer tests over which to spread the fixed costs of the laboratory. This, in turn, would result in higher costs per test and a lower likelihood of the fee schedule rates covering the hospital's costs. The hospitals in the West, which lost the most under the fee schedule, also had relatively low occupancy rates.

## Hospital Revenue Reductions Under the Fee Schedules Are Relatively Insignificant

Although on average hospitals are receiving less than full cost recovery under the fee schedules, we estimate that the fee schedule revenue reductions amount to, on average, less than 1 percent of total hospital laboratory costs. Thus, the fee schedule revenue reductions should have relatively little effect on total hospital laboratory revenue.

The portion of total hospital laboratory operating costs represented by the reductions in payments under the fee schedules is shown in table 5.3.

**Table 5.3: Hospital Revenue Reductions as a Percentage of Total Hospital Laboratory Costs**

| | Percentage of total hospital laboratory costs |
|---|---|
| **Region:** | |
| Northeast | 0 |
| North Central | 0.9 |
| South | 0.2 |
| West | 1.1 |
| **Bed size:** | |
| 1 - 149 | 2.1 |
| 150 - 299 | 0.4 |
| 300 - 499 | 0.2 |
| 500 & more | 0.4 |
| **Overall average** | **0.6** |

The relative effect of the revenue reductions was greatest for small hospitals (1 to 149 beds), for which the fee schedule revenue reductions were about 2.1 percent of total hospital laboratory costs.

Some hospitals in each region and bed-size group received more revenues under the fee schedules than they would have received under the cost reimbursement system. In total, 177 of the 583 sample hospitals

made a profit under the fee schedules. On average, these hospitals received fee schedule payments totaling 125 percent of their costs. Table 5.4 shows the proportion of hospitals in each region and bed-size group that profited from Medicare payments under the fee schedules.

**Table 5.4: Percentage of Hospitals That Profited Under the Fee Schedules**

| | Percentage of hospitals |
|---|---|
| **Region:** | |
| Northeast | 40 |
| North Central | 20 |
| South | 38 |
| West | 13 |
| **Bed size:** | |
| 1 - 149 | 20 |
| 150 - 299 | 36 |
| 300 - 499 | 38 |
| 500 & more | 36 |
| **Overall average** | **27** |

## Probable Effect of the Fee Caps and the National Fee Schedule

Our estimates of beneficiary and Medicare program payments and hospital revenues were made from data covering a time period that generally predated the fee rate caps discussed in chapters 2 and 4. Therefore, the estimates above do not normally account for reductions resulting from those caps.

As discussed in chapter 4, we estimated that the 115 percent of median cap, which was implemented on July 1, 1986, has reduced Medicare payments to physicians and independent laboratories by about 5 percent. When the 110 percent of median cap is imposed on January 1, 1988, the total reduction will be about 6.4 percent. Because the hospital and physician/independent laboratory fee schedule rates are proportionately related, we would expect that the caps will have a similar effect on hospital payments for clinical laboratory services.

When the 110 percent of median cap is imposed, we estimate that the Medicare program will be paying about 24 percent more, on a weighted basis, for hospital clinical laboratory services than under the cost reimbursement system, compared to our estimate of about 32 percent more under the fee schedule before the effect of the caps is considered. Hospitals will then be reimbursed for about 83 percent of their costs, compared to our estimate of about 89 percent of costs before the caps.

At the 110 percent capped levels, we estimate that hospitals will be receiving, nationwide, about $48 million less in Medicare payments than the estimated cost of rendering the services. This amount is less than 1 percent of total laboratory cost center operating costs and, therefore, a very small amount of overall hospital revenues.

Some hospitals may experience some additional reduction in fee schedule revenues for outpatient clinical laboratory services as a result of the OBRA provision that eliminates the 2-percent fee rate differential (62 versus 60 percent fee schedule rate) for hospitals that do not operate emergency rooms that are available around-the-clock. We have no data on how many hospitals might be affected by the provision or the proportion of their clinical laboratory services to which the reduction would apply. Therefore, we cannot estimate the effect this factor may have on hospital revenues.

Assuming that a national fee schedule is computed using a weighted average formula applied to the capped fee rates as we discuss in chapter 4, hospitals on average should incur no additional nationwide net payments change from the national fee schedule, but the fee rates for individual carrier state areas may increase or decrease depending on how their rates compare with the national weighted averages. We estimated the effects of a national fee schedule on many carrier state areas in chapter 4, and we would expect a similar effect on the hospitals within those states.

## Conclusions

Similar to the situation with physicians and independent laboratories, the fee schedule payment system for clinical laboratory services provided to hospital outpatients and referred patients has produced a significant savings for beneficiaries. Those savings were the net effect of increased Medicare payments and reduced total hospital revenues for clinical laboratory services.

The Medicare program will still be paying more for outpatient and referred patient clinical laboratory services after the 110 percent of median cap is imposed than it was under the cost reimbursement system, but the differential will be lessened.

Hospitals are receiving less total revenues for their clinical laboratory services under the fee schedule than they were under the cost reimbursement system, and their revenues will be further reduced by the 110 percent of median fee rate caps. The initial reductions in hospital

revenues that resulted from implementing the fee schedule were about 0.6 percent of total hospital laboratory cost center costs. We believe that the additional reductions that will result from the fee rate caps will also be a relatively small proportion of total hospital laboratory costs.

# Nomenclature of Laboratory Procedures Used in Modeling a National Fee Schedule

| Procedure | HCPCS[a] procedure code | Nomenclature |
|---|---|---|
| A | 80004 | Automated multichannel tests—4 |
| B | 80012 | Automated multichannel tests—12 |
| C | 80016 | Automated multichannel tests—13 to 16 |
| D | 80018 | Automated multichannel tests—17 to 18 |
| E | 80019 | Automated multichannel tests—19 or more |
| F | 81000 | Urinalysis, routine, with microscopy |
| G | 82270 | Occult blood, feces |
| H | 82643 | Digoxin, RIA |
| I | 82756 | Free thyroxine index |
| J | 82947 | Glucose, except urine |
| K | 82948 | Glucose, blood, stick test |
| L | 84132 | Potassium, blood |
| M | 84435 | Thyroxine |
| N | 84436 | Thyroxine, true, RIA |
| O | 84443 | Thyroid stimulating hormone, RIA |
| P | 84478 | Triglycerides, blood |
| Q | 84479 | Triiodothyronine, resin uptake |
| R | 84480 | Triiodothyronine, true, RIA |
| S | 85007 | Blood count, differential white blood cell count |
| T | 85021 | Blood count, hemogram, automated |
| U | 85022 | Blood count, hemogram with differential white blood cell count, automated |
| V | 85028 | Blood count, hemogram and differential white blood cell count and platelet count, automated |
| W | 85031 | Blood count, hemogram, manual, complete blood count |
| X | 85580 | Platelet count |
| Y | 85610 | Prothrombin time |
| Z | 85650 | Sedimentation rate, Wintrobe type |
| AA | 86151 | Carcinoembryonic antigen, RIA |
| AB | 87070 | Culture, bacterial, definitive, aerobic; any other source |
| AC | 87086 | Culture, bacterial, urine, quantitative, colony count |
| AD | 87184 | Sensitivity studies, antibiotic, 12 or fewer discs |

[a]HCFA Common Procedure Coding System.

# Effect of Fee Rate Caps and a Weighted Average National Fee Schedule

| Carrier area | Medicare payments applying | | | Percentage of change in payments | | |
|---|---|---|---|---|---|---|
| | 1985 carrier fee | 1985 fee capped at 110 percent of median rates | Weighted fee using capped fee rates | 1985 carrier fee to capped rates | Capped rates to weighted fee schedule | Net change from carrier fee to weighted fee |
| Texas | $21,969,127 | $17,283,838 | $16,161,301 | −21.3% | −6.5% | −26.4% |
| Hawaii, Guam, Amer. Samoa | 1,274,348 | 1,070,174 | 966,009 | −16.0 | −9.7 | −24.2 |
| Alaska | 121,227 | 100,140 | 92,535 | −17.4 | −7.6 | −23.7 |
| Southern California | 41,352,330 | 34,662,746 | 31,811,463 | −16.2 | −8.2 | −23.1 |
| North Dakota | 2,280,360 | 1,967,062 | 1,847,952 | −13.7 | −6.1 | −19.0 |
| West Virginia | 4,533,828 | 3,912,629 | 3,736,270 | −13.7 | −4.5 | −17.6 |
| Northern California | 13,972,312 | 12,326,483 | 11,866,396 | −11.8 | −3.7 | −15.1 |
| Nevada | 1,065,304 | 992,522 | 915,199 | −6.8 | −7.8 | −14.1 |
| Montana | 1,327,155 | 1,197,736 | 1,141,741 | −9.8 | −4.7 | −14.0 |
| Oklahoma | 4,377,521 | 4,061,759 | 3,833,868 | −7.2 | −5.6 | −12.4 |
| Mississippi | 3,390,108 | 3,107,438 | 2,972,162 | −8.3 | −4.4 | −12.3 |
| Kansas | 4,718,055 | 4,520,771 | 4,173,227 | −4.2 | −7.7 | −11.5 |
| Illinois | 12,200,461 | 11,533,027 | 11,011,996 | −5.5 | −4.5 | −9.7 |
| Minnesota-Travelers | 3,775,250 | 3,466,684 | 3,420,591 | −8.2 | −1.3 | −9.4 |
| Minnesota Blue Shield | 3,605,553 | 3,419,389 | 3,304,512 | −5.2 | −3.4 | −8.3 |
| Florida | 39,697,635 | 38,426,529 | 36,803,401 | −3.2 | −4.2 | −7.3 |
| Arkansas | 4,745,432 | 4,626,523 | 4,401,222 | −2.5 | −4.9 | −7.3 |
| Virginia | 6,837,917 | 6,270,768 | 6,353,442 | −8.3 | 1.3 | −7.1 |
| District of Columbia | 7,135,344 | 6,703,212 | 6,744,527 | −6.1 | 0.6 | −5.5 |
| Massachusetts | 19,756,726 | 19,065,506 | 18,848,332 | −3.5 | −1.1 | −4.6 |
| Missouri | 4,622,285 | 4,368,598 | 4,421,691 | −5.5 | 1.2 | −4.3 |
| Rhode Island | 5,138,798 | 4,961,407 | 4,927,678 | −3.5 | −0.7 | −4.1 |
| Idaho | 611,798 | 591,992 | 588,747 | −3.2 | −0.5 | −3.8 |
| South Dakota | 1,043,314 | 1,023,671 | 1,023,288 | −1.9 | [a] | −1.9 |
| Ohio | 33,784,566 | 32,323,349 | 33,233,094 | −4.3 | 2.8 | −1.6 |
| Indiana | 4,758,224 | 4,624,253 | 4,725,973 | −2.8 | 2.2 | −0.7 |
| Pennsylvania | 30,287,959 | 29,886,497 | 30,666,665 | −1.3 | 2.6 | 1.3 |
| Colorado | 3,651,796 | 3,542,676 | 3,701,168 | −3.0 | 4.5 | 1.4 |
| Alabama | 7,360,016 | 7,333,537 | 7,516,499 | −0.4 | 2.5 | 2.1 |
| Georgia | 4,921,648 | 4,902,044 | 5,030,017 | −0.4 | 2.6 | 2.2 |
| Connecticut | 4,366,757 | 4,198,436 | 4,502,940 | −3.9 | 7.3 | 3.1 |
| Oregon | 3,718,752 | 3,677,508 | 3,839,191 | −1.1 | 4.4 | 3.2 |
| Washington | 7,798,509 | 7,765,524 | 8,156,939 | −0.4 | 5.0 | 4.6 |
| Maine | 808,282 | 807,631 | 852,083 | −0.1 | 5.5 | 5.4 |
| Arizona | 5,381,410 | 5,332,179 | 5,713,556 | −0.9 | 7.2 | 6.2 |
| Iowa | 6,812,303 | 6,733,526 | 7,315,673 | −1.2 | 8.6 | 7.4 |

(continued)

| Carrier area | Medicare payments applying | | | Percentage of change in payments | | |
|---|---|---|---|---|---|---|
| | 1985 carrier fee | 1985 fee capped at 110 percent of median rates | Weighted fee using capped fee rates | 1985 carrier fee to capped rates | Capped rates to weighted fee schedule | Net change from carrier fee to weighted fee |
| Delaware | 631,126 | 616,496 | 677,916 | −2.3 | 10.0 | 7.4 |
| Greater New York City | 22,879,212 | 22,537,448 | 24,841,666 | −1.5 | 10.2 | 8.6 |
| Western New York | 3,627,209 | 3,585,911 | 4,148,452 | −1.1 | 15.7 | 14.4 |
| Utah | 1,047,324 | 1,046,529 | 1,222,681 | −0.1 | 16.8 | 16.7 |
| North Carolina | 5,932,199 | 5,890,123 | 6,951,909 | −0.7 | 18.0 | 17.2 |
| **Total** | **$357,319,480** | **$334,464,271** | **$334,463,972** | | | |
| **Average** | | | | **−6.4%** | **0.0%** | **−6.4%** |

[a]Less than 0.1%.

# Description of Sample Method for GAO's Survey of Hospitals

We used a sample originally developed by HCFA to validate the first year prospective payment rates for inpatient hospital services. HCFA stratified this sample into 4 bed-size groups and 4 regions; this resulted in a sample composed of 16 cells. Within each region and bed size, hospitals were selected randomly.

The four bed-size groups were:

- 1 to 149 beds.
- 150 to 299 beds.
- 300 to 499 beds.
- 500 and more beds.

The four regions and jurisdictions within each were:

Northeast

- Connecticut.
- Maine.
- Massachusetts.
- New Hampshire.
- New Jersey.
- New York.
- Pennsylvania.
- Rhode Island.
- Vermont.

North Central

- Illinois.
- Indiana.
- Iowa.
- Kansas.
- Michigan.
- Minnesota.
- Missouri.
- Nebraska.
- North Dakota.
- Ohio.
- South Dakota.
- Wisconsin.

South

- Alabama.
- Arkansas.

- Delaware.
- District of Columbia.
- Florida.
- Georgia.
- Kentucky.
- Louisiana.
- Maryland.
- Mississippi.
- North Carolina.
- Oklahoma.
- South Carolina.
- Tennessee.
- Texas.
- Virginia.
- West Virginia.

West

- Alaska.
- Arizona.
- California.
- Colorado.
- Hawaii.
- Idaho.
- Montana.
- Nevada.
- New Mexico.
- Oregon.
- Utah.
- Washington.
- Wyoming.

Table III.1 shows the number of hospitals in each cell from the universe (after adjusting for areas and specific hospitals that were exempt from fee schedule payment) and the sample as well as the number that responded to our questionnaire.

**Table III.1: Number of Hospitals in Each Cell in the Universe and the Sample and the Number Responding to GAO's Questionnaire**

| | | Number of hospitals | | | |
|---|---|---|---|---|---|
| **Region** | **Bed size** | **Universe** | **Sample** | **Respondents** | **Usable responses** |
| Northeast | Unknown | | | 5 | |
| | 1 - 149 | 236 | 37 | 31 | 15 |
| | 150 - 299 | 213 | 39 | 30 | 22 |
| | 300 - 499 | 105 | 31 | 32[a] | 20 |
| | 500 or more | 63 | 50 | 37 | 29 |
| North Central | Unknown | | | 14 | |
| | 1 - 149 | 1,100 | 164 | 123 | 87 |
| | 150 - 299 | 297 | 54 | 50 | 32 |
| | 300 - 499 | 204 | 48 | 47 | 30 |
| | 500 or more | 100 | 72 | 53 | 51 |
| South | Unknown | | | 24 | |
| | 1 - 149 | 1,408 | 208 | 139 | 76 |
| | 150 - 299 | 382 | 71 | 56 | 35 |
| | 300 - 499 | 205 | 48 | 50[a] | 30 |
| | 500 or more | 109 | 98 | 72 | 61 |
| West | Unknown | | | 15 | |
| | 1 - 149 | 722 | 118 | 76 | 45 |
| | 150 - 299 | 220 | 40 | 33 | 20 |
| | 300 - 499 | 106 | 26 | 22 | 14 |
| | 500 or more | 26 | 26 | 20 | 16 |
| | **Totals** | **5,496** | **1,130** | **929** | **583** |

[a]Certain respondents reported bed sizes that were different from the group they represented in the original sample. When weighting the responses, we assigned the usable responses to the region and bed-size strata of the original sample.

Weighted for the respondents, our sample represents 2,628 hospitals (48 percent of the universe). In chapter 5, we made several projections for the hospitals represented by our respondents. Those projections and corresponding sampling errors (at 95 percent confidence) are:

- Beneficiary savings under the fee schedule—$93 million; +/− $8 million.
- Increased Medicare payments under the fee schedule—$61 million; +/− $11 million.
- Total Medicare payments to hospitals for outpatient laboratory services—$250 million; +/− $24 million.
- Costs of providing outpatient laboratory services to Medicare beneficiaries—$282 million; +/− $24 million.

# Comments From the Department of Health and Human Services

Note: GAO comments supplementing those in the report text appear at the end of this appendix.

DEPARTMENT OF HEALTH & HUMAN SERVICES — Office of Inspector General

OCT 21 1987

Mr. Richard L. Fogel
Assistant Comptroller General
U.S. General Accounting Office
Washington, D.C. 20548

Dear Mr. Fogel:

The Secretary asked that I respond to your request for the Department's comments on your draft report, "Medicare: Laboratory Fee Schedules Produced Large Beneficiary Savings But No Program Savings." The enclosed comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

We appreciate the opportunity to comment on this draft report before its publication.

Sincerely yours,

Richard P. Kusserow
Inspector General

Enclosure

Comments of the Department of Health and Human Services
on the General Accounting Office Draft Report,
"Laboratory Fee Schedules Produced Large
Beneficiary Savings But No Program Savings"

See comment 1.

To assess the appropriateness of the Medicare fee schedule payment system, GAO looked at its effects on payments, beneficiary access to laboratory services and quality of services. According to GAO, the fee schedules saved beneficiaries substantial amounts of money, increased Medicare costs somewhat, did not affect beneficiary access to laboratory services, and had no material effect on quality. As a result, GAO concludes that the fee schedule payment system met its objectives, except for saving Medicare money. Accordingly, GAO recommends that the Congress enact legislation to provide the Health Care Financing Administration (HCFA) more latitude in setting national fee schedule rates so that Medicare costs will not increase.

We are in agreement with GAO's recommendation that the Congress amend section 1833(h) of the Social Security Act to relieve HCFA of the requirement to use prevailing charges as the basis for the national fee schedule. In addition, we offer the following technical comments.

See comment 2.

We agree with GAO's conclusion that the fee schedule payment system did not meet one of its objectives; i.e., saving Medicare money. We differ, however, with the GAO finding that Medicare costs increased only by a small degree. A study conducted in 1986 by HCFA indicated a substantially increased Federal pay-out under fee schedules.

As a result of discussions between HCFA and GAO, we believe the GAO figures of added Federal payments should have been considerably higher for the following reasons. First, in analyzing the data received from carriers, GAO combined certain procedures under various procedure codes, often resulting in lower fee schedule reimbursement amounts. Second, GAO adjusted the base reasonable charge payments for inflation, when they should not have been inflated, to calculate the real dollar payment difference. Finally, regarding the type of data used in establishing reasonable charge system payments, GAO used 80 percent of the carrier-supplied allowable charges as the base figure. Conversely, HCFA used actual paid data supplied by carriers, which often proved to be considerably less than 80 percent of the allowable charges. This further minimized the increases in converting to the fee schedule.

See comment 3.
Now on p. 13.

The Deficit Reduction Act of 1984 (DEFRA) requirement that appears at the top of page 5 (that independent laboratories are required to accept Medicare assignment on all clinical diagnostic service claims) is not technically accurate. Rather, DEFRA required that payment for clinical diagnostic laboratory tests performed by a laboratory which is independent of a physician's office may only be made on the basis of assignment. DEFRA did not require independent laboratories to accept assignment. This is also true of the Consolidated Omnibus Budget Reconciliation Act of 1985 provision, described on page 6, regarding physician acceptance of assignment. Since unassigned claims for clinical laboratory services are not covered, overall beneficiary savings from coinsurance on assigned claims is reduced to the extent physicians and laboratories do not accept assignment.

Now on p. 14.

See comment 4.
Now on p. 29.



In addition, we believe that the discussion concerning the decline in provider revenues on page 26 should mention the fact that the amounts charged the program by physicians in past periods often reflected the physicians' markup and were not the actual charges of the independent laboratory. In Florida and Pennsylvania, the low allowances prior to the fee schedule were in large measure based on the charge submitted by the laboratory to the physician. As a result of the direct billing requirement, revenues have probably increased for tests now billed by many independent laboratories. Also, mention should be made that beneficiaries were not always charged for coinsurance prior to implementation of this provision; rather, the physician or laboratory would accept the Medicare-allowed amount as payment in full. This would further mitigate the seemingly significant loss of revenue that occurred after implementation.

The following are GAO's comments on the Department of Health and Human Services' letter dated October 21, 1987.

## GAO Comments

1. After sending the draft report to HHS for comments, we performed additional legal analysis of the changes made by OBRA to the laboratory fee schedule legislation. Based on this analysis, we believe that HCFA is not required to use prevailing charges to compute a national fee schedule. Therefore, we are no longer recommending that the legislation be amended to remove the original DEFRA requirement. The reasons for our opinion that OBRA already removed that requirement are discussed below.

OBRA amended section 1833(h) of the Social Security Act, which had been added by DEFRA, with respect to a national fee schedule, in three ways:

- the date for establishing a national fee schedule was advanced to January 1, 1990;
- reference to the national fee schedule was deleted from the provision setting forth a methodology for computing fee schedules (section 1833(h)(2)); and
- the Secretary of HHS was required to report to the Congress, by April 1, 1988, on the advisability and feasibility of, and the methodology for, establishing national fee schedules.

Therefore, it is our view that no particular methodology for computing the 1990 national fee schedule is set forth or required by current legislation. HCFA believes that it must use the "prevailing rates" methodology of section 1833(h)(2) in establishing a national fee schedule, notwithstanding the OBRA changes.

2. HHS said that a study conducted by HCFA in 1986 showed the fee schedule payment system cost the program a substantial sum. HHS offered three reasons for the difference between HCFA's estimate of increased costs and our estimate—namely, that we (1) combined some procedures under various procedure codes; (2) adjusted the base reasonable charge payments for inflation, when they should not have been inflated; and (3) used 80 percent of the carrier-supplied reasonable charge data as the base figure.

We believe that our estimate is more accurate than HCFA's and that we appropriately handled the three factors HHS raised. First, we did not

combine laboratory procedures. During the time that carriers were implementing the fee schedule payment system, some carriers were also converting their procedure coding system to HCPCS. This required some translation from local carrier procedure coding systems, and clear matches from those local systems to the HCPCS procedure codes did not always exist. We did not compare reasonable charge payments with fee schedule payments for any procedures that we could not determine were the same under a local coding system and HCPCS. As explained in chapter 2, we attempted to compare pre-fee schedule payments with fee schedule payments for 76 procedures that accounted for about 90 percent of total payments for clinical laboratory services in the 14 carrier areas. Because we could not always make clear translations from the local coding system to HCPCS in all carrier areas, our comparisons are based on from 70 to 76 procedures in the 14 areas.

We computed the amount Medicare paid for the 70 to 76 procedures under the reasonable charge system. We inflated the reasonable charge amounts by the Medicare economic index of 3.3 percent to estimate the amount Medicare would have paid if the fee schedule payment system had not been implemented. We compared those estimated reasonable charge payments with the actual amount paid under the fee schedule payment system. We believe this inflation adjustment was appropriate because in the absence of legislation, outpatient laboratory reasonable charges would have been adjusted under the normal reasonable charge process.

In computing the base figure, we used the carrier allowed amount, not the allowable charge, as HHS said in its comments. The allowed amount is the amount payments are based on, and under the reasonable charge system, the allowed amount is generally the lowest of the amount charged by the supplier, the supplier's usual charge for the service, or the prevailing charge among all suppliers in the area for that service. Under the fee schedule payment system, the allowed amount is the lower of the amount charged by the supplier or the fee schedule amount.

We believe that the difference between HCFA's estimate and ours is primarily due to (1) the number and type of procedures included in the comparison of payments and (2) our use of the allowed amount and assignment status in computing Medicare payments under the fee schedule.

First, HCFA's comparison was based on 20 tests, including 10 LCL procedures, 5 automatable clinical chemistry blood tests, and 5 other procedures. We used 70 to 76 procedures, including all 12 LCL procedures, up to 14 automatable clinical chemistry blood tests, and up to 50 other high-volume procedures. In table 2.2, our results show that payments under the fee schedule increased 11.4 percent for the LCL procedures, increased 4.6 percent for the automatable tests, but decreased 2.7 percent for the other high-volume tests. Those high-volume tests accounted for over 50 percent of total payments under the fee schedule, and largely offset the increases from the other two categories. HCFA's comparison is based primarily on the LCL and automatable tests.

Second, in estimating Medicare payments under the fee schedule, HCFA assumed all claims for laboratory services were paid at the fee schedule rate, thus overstating the amount paid under the fee schedule. In our estimates, we used the allowed amount; that is, the lower of the amount charged for the test or the fee schedule rate. Also, our estimate considered the lower Medicare payment on unassigned claims (80 percent of the allowed amount rather than 100 percent of it). In chapter 2, we reported that 22 percent of physicians' and independent laboratories' claims for laboratory services in the first year of the fee schedule payment system were unassigned. We believe our estimate, which is based on procedures that collectively account for about 90 percent of total payments for clinical laboratory services in the 14 carrier areas and considered allowed amounts and assignment status, is more accurate than HCFA's estimate.

3. HCFA's phrasing of this requirement is more technically accurate, and we have revised the report as suggested.

4. HHS mentioned two considerations that may partially offset the reductions in suppliers' revenue that we estimated may have occurred under the fee schedule payment system.

HHS says that before the fee schedule, physicians who purchased services from independent laboratories paid the laboratory a discounted fee for the service and marked up their charge to the Medicare program. The fee schedule was based on charges submitted to Medicare, which may be inflated due to those physician markups. HHS postulates that fee schedule payment amounts may closely approximate the payments independent laboratories received from physicians, and thus independent laboratory revenues may not have been reduced by the fee schedule

payment system. HHS said "revenues have probably increased for tests now billed by many independent laboratories."

We believe that the increases HHS postulates, if true, would be found in only a portion of the bills submitted by independent laboratories under the fee schedule. Data we analyzed from 14 carriers show that about 30 percent of all bills for laboratory services before the fee schedule payment system was implemented were billed directly by independent laboratories, and those bills would not have contained physician markups. Of the remaining bills for laboratory services, some would have been for physician-purchased services (an unknown portion of which may have included physician markups) and some would have been for services performed or supervised by the physician within his or her office laboratory.

HHS also says that before the fee schedule was implemented, physicians and independent laboratories may not have always collected coinsurance from beneficiaries for laboratory services, and thus the elimination of coinsurance under the fee schedule may not have affected supplier revenue.

If suppliers were not collecting the required coinsurance, the carriers should have reduced the suppliers' allowed charges by 20 percent to reflect the lower charge accepted by the supplier. To the extent that suppliers were not following the prescribed procedures on collecting coinsurance before the fee schedule was implemented, HHS's comments on this issue would be correct.

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