Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REIMBURSEMENT FOR OUTPATIENT FACILITY SERVICES

MANAGEMENT ADVISORY REPORT

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INSPECTOR GENERAL

OEI-09-88-01003

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REIMBURSEMENT FOR OUTPATIENT FACILITY SERVICES
OEI-09-88-01003

PURPOSE

This report compares Medicare payments for facility services in ambulatory surgery centers (ASCs) and hospital outpatient departments (OPDs).

BACKGROUND

Under the Sixth Omnibus Budget Reconciliation Act of 1986 (SOBRA), which was effective July 1987, the Health Care Financing Administration (HCFA) began reimbursing OPDs the lesser of (1) the hospital's reasonable or customary charges for outpatient surgical facility services or (2) a blend of current OPD hospital-specific costs and ASC prospective payment rates for each procedure. For the cost reporting periods beginning October 1987, the blended rate was 75 percent of the OPD hospital-specific cost and 25 percent of the ASC rate. The blended rate was changed to a 50-50 percent ratio in October 1988. Effective January 1991, OPD reimbursement was changed under the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990) by (1) reducing OPD hospital-specific costs by 5.8 percent and (2) using this reduced amount in the new blended rate of 42 percent of the OPD hospital-specific costs and 58 percent of the ASC rates.

We recently completed an inspection in which we examined Medicare outpatient surgery performed in ASCs and OPDs. In February 1991, we released the medical outcome analysis in a final report entitled "Outpatient Surgery--Medical Necessity and Quality of Care" (OEI-09-88-01000).

METHODOLOGY

We selected three high-volume Medicare procedures--cataract extraction with intraocular lens (IOL) implant, upper gastrointestinal (GI) endoscopy, and colonoscopy. We selected a random sample of 1,162 Medicare beneficiaries, half of whom had their surgeries in ASCs and half in OPDs during the first quarter of calendar year 1988. The surgeries were performed in the 10 States with the highest number of Medicare-certified ASCs in February 1988.

We determined OPD and ASC paid amounts by reviewing the beneficiary histories and claims obtained from the Medicare carriers and fiscal intermediaries. For OPDs, the paid amounts represent the interim payments. These interim payments are subject to adjustment based on the intermediary's audit of the hospital cost report for the fiscal year in which the services were rendered. Our analysis included surgeons' fees, facility fees, preoperative tests, postoperative office visits, and IOL charges. In order to gain a national perspective, we made two non-statistical projections from the data. First, we projected the 10 States' quarterly costs to

annual costs. Second, since the cost of sampled procedures represents 49 percent of the Medicare procedures performed nationally, we calculated the national costs by dividing the sampled costs by 0.49. This methodology assumes the 10 sampled States are representative of the nation as a whole. In appendix A, we have included additional information concerning the basis under which we (1) collected and analyzed the data and (2) calculated the cost savings.

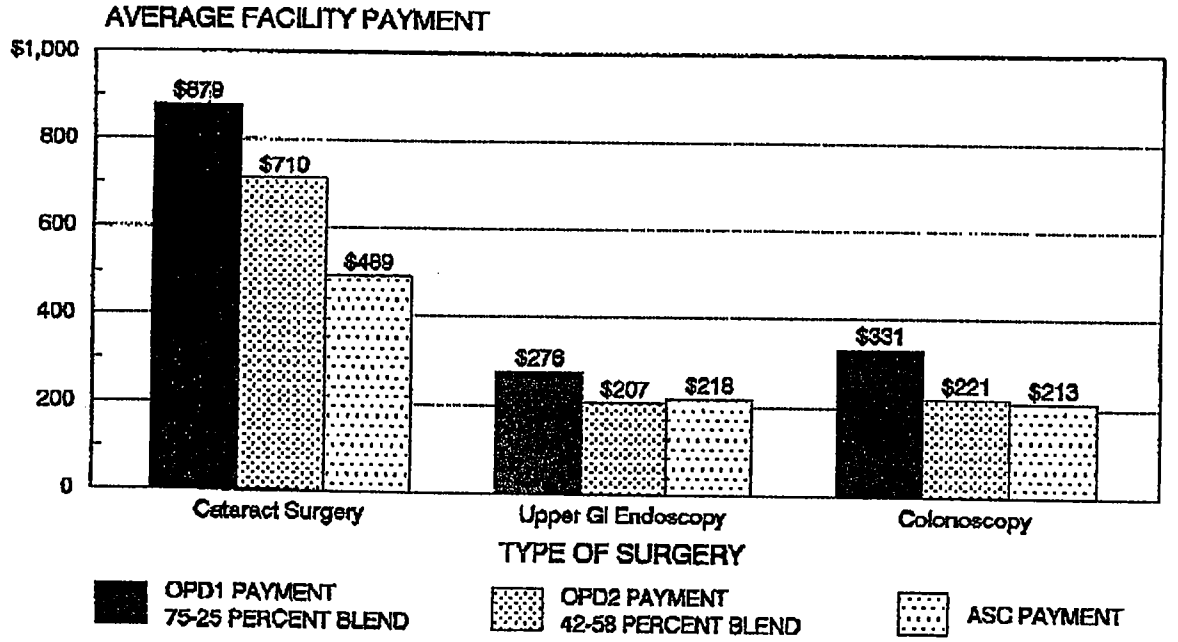
FINDING

DIFFERENCES EXIST IN MEDICARE PAYMENTS TO OPDs AND ASCs

In 1988, Medicare payments to OPDs exceeded payments to ASCs by 26.3 percent for upper GI endoscopies, 43.8 percent for colonoscopies, and 73.6 percent for cataract surgeries. In our sample, the weighted OPD facility payments averaged $276 for upper GI endoscopies, $331 for colonoscopies, and $879 for cataract surgeries. The ASC facility payments averaged $218 for upper GI endoscopies, $213 for colonoscopies, and $489 for cataract surgeries.

To compare these figures with OPD payments under the current reimbursement system, we converted the 1988 OPD data from the 75-25 percent blended rate to the estimated 42-58 percent blended rate. We based the average 42-58 percent blended rate for the sampled procedures on State averages. Under the 42-58 percent blended rate, the sampled OPDs still would have been paid more for facility fees than ASCs for 2 procedures--4.1 percent more for colonoscopies and 44.9 percent more for cataract surgeries. On the other hand, OPDs would have been paid 5.0 percent less than ASCs for upper GI endoscopies. The chart on the next page compares the OPD payments under the two blended rates to ASC payments.

DIFFERENCES EXIST IN OPD AND ASC FACILITY FEE PAYMENTS



Even under the 42-58 percent OPD blended rate, differences exist in Medicare payments to OPDs and ASCs at the State level. For cataract surgeries, OPDs are paid more than ASCs in all sampled States. The differences ranged from $56.62 in Arizona to $442.96 in Maryland.

Although the above chart illustrates near parity in facility fee payments for upper GI endoscopies and colonoscopies, fiscal intermediaries in several States make substantially different payments based on the setting. For colonoscopies, Florida OPDs are paid $90.59 more than ASCs, while Louisiana ASCs are paid $86.17 more than OPDs. For upper GI endoscopies, Maryland OPDs are paid $58.92 more than ASCs, while Arizona ASCs are paid $69.72 more than OPDs.

The OPDs allege that they should receive higher reimbursement than ASCs because they (1) treat patients with concomitant conditions such as hypertension or diabetes and (2) maintain standby equipment and staff for emergencies. As discussed in our report entitled "Outpatient Surgery--Medical Necessity and Quality of Care," we found no significant differences between OPDs and ASCs with respect to concomitant conditions, average patient age, ability to resolve intraoperative complications, or quality of care.

Using the 42-58 percent blended rate, we estimate the difference in Medicare payments between OPDs and ASCs in our sample was $14.43 million per quarter. This difference projects to approximately $57.70 million annually for 1988. If one

assumes our 10-State sample is representative of the nation, the difference in payments between OPDs and ASCs was approximately $117.76 million in 1988.

RECOMMENDATION

- **THE HCFA SHOULD SEEK LEGISLATION TO ACHIEVE PARITY IN ASC AND OPD PAYMENTS.**

AGENCY COMMENTS

The HCFA has agreed with our recommendation to seek legislation to achieve parity in ASC and OPD payments. As a result, a HCFA legislative proposal is included in the Fiscal Year 1992 Budget. The proposal would establish uniform payments for ASCs and OPDs. The ASCs and OPDs would receive the same payment–the lower of either the (1) OPD payment (under the 42-58 percent blended rate) or (2) ASC rate. The HCFA would implement the new rates for high volume outpatient surgical procedures in 1992 and phase in other surgical procedures at a later date.

The HCFA disagreed with the OIG estimated cost savings in the draft report, because we did not calculate them based on the current 42-58 percent blended rate for OPDs. While HCFA agrees that OPD payment is significantly higher than ASC payment for cataract surgery, they believe the opposite is true for upper GI endoscopies and colonoscopies under the current 42-58 percent blended rate.

The complete text of the comments is contained in appendix B.

OFFICE OF INSPECTOR GENERAL RESPONSE

Based on HCFA's comments, we have recalculated our cost savings based on the current 42-58 percent blended rate and incorporated the revised cost savings into the finding. According to our data, OPDs still receive more than ASCs for cataract surgeries and colonoscopies while they receive less for upper GI endoscopies. The following savings will be achieved through parity–$107.61 million for cataract surgery, $5.62 million for upper GI endoscopies, and $4.53 million for colonoscopies.

While there still may be disagreements about the cost savings between the two settings, we want to emphasize that we do agree with HCFA's legislative proposal to set parity in both outpatient settings.

APPENDIX A

METHODOLOGY

Facility Fees

We determined OPD and ASC paid amounts by reviewing the beneficiary payment histories and claims that we obtained from the Medicare carriers and fiscal intermediaries. For OPDs, the paid amounts represent the interim payments. These interim payments are subject to adjustment based on the intermediary's audit of the hospital cost report for the fiscal year in which the services were rendered. We analyzed all paid amounts including surgeons' fees, facility fees, preoperative tests, postoperative office visits within 90 days after surgery, and IOL charges for cataract cases.

In OPD cataract cases, we (a) identified the amount that was paid for the IOL from the claim or patient history if it was billed by the hospital and (b) subtracted it from the total amount. The remainder was the payment for the facility fee. If we could not isolate the IOL payment, we contacted the hospital for this information. Since IOLs were billed separately by ASCs during the review period, there was no need for us to deduct them from the facility fee payment for the cataract surgery cases.

In several cases, we excluded records from our analysis because (a) Medicare was the secondary payor, and thus, the program paid minimal amounts, if any, or (b) the intermediaries could not locate any claims.

Converting OPD Payments From 75-25 Percent Blended Rates to 42-58 Percent Blended Rates

The data collected for this inspection represent a 3-month period in which OPD facilities were reimbursed at a blended rate of 75 percent of OPD hospital-specific costs and 25 percent of the comparable ASC facility fee. In order to project potential cost savings for the options, we converted the payments from the 75-25 percent blended rates to the 42-58 percent blended rates that were effective January 1991. We estimated the OPD facility costs by first subtracting (a) the beneficiary coinsurance and deductibles and (b) 25 percent of the ASC facility fee paid by the Medicare program (i.e., 80 percent of the ASC allowed amount) from the OPD allowed amount. We divided this intermediate amount by 0.75, thus obtaining the estimated average historical cost that the fiscal intermediary uses to determine the blended rate.

Effective January 1, 1991, Section 4151 of the Omnibus Budget Reconciliation Act (OBRA) of 1990 reduced the OPD reimbursement to a 42-58 percent blended rate. To calculate the current rate, we (a) reduced the OPD hospital-specific cost amount by 5.8 percent, (b) took 42 percent of this reduced amount, and (c) blended this

amount with 58 percent of the ASC prospective payment rate. Since the 15 percent OPD capital cost adjustment was not effective in 1988, we did not include this adjustment in our estimated 42-58 percent blended rates. We based the average 42-58 percent blended rate for the sampled surgeries on State averages. By comparing the 75-25 percent blended rate to the estimated 42-58 percent blended rate, we calculated the estimated savings between ASC and OPD facility payments.

Cost Estimates and National Projections

Upon reviewing the beneficiary payment histories, we eliminated surgeries that were incorrectly coded for ASCs or OPDs and then substituted additional cases to achieve the desired sample size. Thus, we adjusted the sample to account for the histories that contained errors. We used the adjusted sample to develop the cost estimates for the first quarter of 1988. In addition, we used the estimated 42-58 percent blended rate for OPD reimbursement for our cost projections.

Since our sample represented one quarter of the year, we multiplied the quarter's projections by four to calculate the annual estimates for the procedures. Also, since our sample costs represented 49 percent of all surgeries performed nationally, we divided the annual estimates by 0.49 to obtain national projections.

The tables on the following pages present the savings if ASCs and OPDs receive the same payment for cataract surgeries, upper GI endoscopies, and colonoscopies.

TABLE 1: ESTIMATED ANNUAL SAVINGS FOR CATARACT SURGERY IF ASCs AND OPDs RECEIVED SAME REIMBURSEMENT

STATE	AVERAGE SAVINGS PER CASE	ADJUSTED SITE UNIVERSE	AVERAGE QUARTERLY SAVINGS	ESTIMATED ANNUAL SAVINGS
ARIZONA	$56.62	1468	$83,118.16	$332,472.64
CALIFORNIA	$296.73	5228	$1,551,304.44	$6,205,217.76
FLORIDA	$332.61	15470	$5,145,476.70	$20,581,906.80
ILLINOIS	$200.29	3262	$653,345.98	$2,613,383.92
LOUISIANA	$100.95	3904	$394,108.80	$1,576,435.20
MARYLAND	$442.96	1759	$779,166.64	$3,116,666.56
NORTH CAROLINA	$97.66	2633	$257,138.78	$1,028,555.12
OHIO	$181.18	7388	$1,338,557.84	$5,354,231.36
PENNSYLVANIA	$124.52	8034	$1,000,393.68	$4,001,574.72
TEXAS	$149.27	13260	$1,979,320.20	$7,917,280.80
TOTALS:	$1,982.79	62406	$13,181,931.22	$52,727,724.88

ESTIMATED NATIONAL ANNUAL SAVINGS FOR CATARACTS:

$107,607,601.80

TABLE 2: ESTIMATED ANNUAL SAVINGS FOR UPPER GI ENDOSCOPY IF ASCs AND OPDs RECEIVED SAME REIMBURSEMENT

	AVERAGE SAVINGS PER CASE	ADJUSTED SITE UNIVERSE	AVERAGE QUARTERLY SAVINGS	ESTIMATED ANNUAL SAVINGS
ARIZONA	$69.72	10	$697.20	$2,788.80
CALIFORNIA	$16.77	1781	$29,867.37	$119,469.48
FLORIDA	$74.93	6849	$513,195.57	$2,052,782.28
ILLINOIS	$0.00	0	$0.00	$0.00
LOUISIANA	$65.50	33	$2,161.50	$8,646.00
MARYLAND	$58.92	1493	$87,967.56	$351,870.24
NORTH CAROLINA	$8.38	18	$150.84	$603.36
OHIO	$21.71	60	$1,302.60	$5,210.40
PENNSYLVANIA	$27.56	41	$1,129.96	$4,519.84
TEXAS	$13.50	3888	$52,488.00	$209,952.00
TOTALS:	$356.99	14173	$688,960.60	$2,755,842.40

ESTIMATED NATIONAL ANNUAL SAVINGS FOR UPPER GIs:

$5,624,168.16

TABLE 3: ESTIMATED ANNUAL SAVINGS FOR COLONOSCOPY
IF ASCs AND OPDs RECEIVED SAME REIMBURSEMENT

	AVERAGE SAVINGS PER CASE	ADJUSTED SITE UNIVERSE	AVERAGE QUARTERLY SAVINGS	ESTIMATED ANNUAL SAVINGS
ARIZONA	$8.58	11	$94.38	$377.52
CALIFORNIA	$4.18	1141	$4,769.38	$19,077.52
FLORIDA	$90.59	4681	$424,051.79	$1,696,207.16
ILLINOIS	$0.00	0	$0.00	$0.00
LOUISIANA	$86.17	15	$1,292.55	$5,170.20
MARYLAND	$76.99	3	$230.97	$923.88
NORTH CAROLINA	$89.05	576	$51,292.80	$205,171.20
OHIO	$50.35	1429	$71,950.15	$287,800.60
PENNSYLVANIA	$33.24	27	$897.48	$3,589.92
TEXAS	$3.48	9	$31.32	$125.28
TOTALS:	$442.63	7892	$554,610.82	$2,218,443.28

ESTIMATED NATIONAL
ANNUAL SAVINGS
FOR COLONOSCOPIES:

$4,527,435.27

APPENDIX B

AGENCY COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

PDIG	✓	
~~DIG-AS~~		
DIG-EI	✓	
DIG-OI		
~~AIG-MP~~	✓	
OGC/IG		
~~EX SEC~~	✓	
~~DATE SENT~~	4/29	

Memorandum

Date APR 29 1991

From Administrator
Health Care Financing Administration

Subject OIG Draft Management Advisory Report - "Reimbursement for Outpatient Facility Services," OEI-09-88-01003

To The Inspector General
Office of the Secretary

We have reviewed the subject management advisory report which compares Medicare payments for facility services in ambulatory surgery centers (ASCs) and hospital outpatient departments (OPDs). This report indicates that Medicare Part B payments to OPDs for facility services associated with cataract surgery, endoscopies, and colonoscopies far exceed payments for the same services when they are provided in an ASC. It also states that significant savings could be achieved by reducing OPD payments for these three services to ASC levels.

However, data which we have reviewed from the Office of the Actuary (OACT) for the first quarter of 1990, adjusted for the Omnibus Budget Reconciliation Act of 1990 (OBRA 90) changes and inflated to 1991, indicate that while payment to OPDs is significantly higher than payment to ASCs for facility services associated with cataract surgery, the opposite is true for endoscopies and colonoscopies. Changing payment for colonoscopies and endoscopies performed in OPDs to the ASC rates would, therefore, result in a budget cost rather than budget savings.

The report recommends that HCFA seek legislation to achieve parity in ASC and OPD payments. We agree with this recommendation and have already developed a legislative proposal, contained in the Fiscal Year 1992 President's Budget, to establish uniform payment across OPDs and ASCs. We are proposing that prospective rates be set at the lower of OPD costs or the current ASC rate, and that the same rate apply whether the service is provided in an OPD or an ASC. These prospective rates would be implemented in 1992 for high volume surgical procedures, with prospective rates phased in subsequently for other ambulatory surgical procedures.

We do question OIG's savings estimate attached to this recommendation. It does not take into account changes made to OPD payment by OBRA 90. These changes extended from OBRA 89 the 15 percent cut in hospital outpatient capital costs, reduced non-capital outpatient costs by 5.8 percent, and reduced the blend of hospital-specific costs and ASC-prospective rates to a 42-58 percent ratio.

We also have the following technical comments:

- On page 1, Background, 1st paragraph: The use of the word "previous" should be deleted. The blended payment amount is based on a blend of a hospital's present costs and ASC payment rates.

- The term "OPD-specific rate," which is used throughout the report, should be changed to "hospital-specific cost." The word "rate" conveys a fixed or prospective amount rather than a specific hospital's cost.

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

Gail R. Wilensky, Ph.D.