Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE AND BENEFICIARIES COULD SAVE BILLIONS IF CMS REDUCES HOSPITAL OUTPATIENT DEPARTMENT PAYMENT RATES FOR AMBULATORY SURGICAL CENTER-APPROVED PROCEDURES TO AMBULATORY SURGICAL CENTER PAYMENT RATES

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Office of Inspector General

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EXECUTIVE SUMMARY

Medicare and beneficiaries could save billions if the Centers for Medicare & Medicaid Services reduces hospital outpatient department payment rates for ambulatory surgical center-approved procedures to the same level as ambulatory surgical center payment rates.

WHY WE DID THIS REVIEW

Medicare covers many outpatient surgical procedures commonly performed in both hospital outpatient departments (outpatient departments) and in ambulatory surgical centers (ASCs). Medicare ASC payment rates are frequently lower than outpatient department payment rates. Thus, Medicare generally saves when outpatient surgical procedures that do not pose significant risk to patients are performed in an ASC instead of an outpatient department. Our review quantifies the impact of this payment differential on aggregate Medicare expenditures for outpatient surgical procedures in the ASC setting as compared with outpatient departments. We completed this review in response to a congressional request, which asked us to assess the impact on total Medicare expenditures of providing surgical services in an ASC as opposed to other outpatient settings.

Our objectives were to determine how much Medicare (1) has saved as a result of procedures being performed in ASCs instead of outpatient departments and (2) could save if payment rates for the outpatient departments were reduced to the same level as ASC payment rates.

BACKGROUND

In 1982, Medicare began covering services provided in ASCs because the Centers for Medicare & Medicaid Services (CMS) recognized that some surgical services provided on an inpatient basis could be safely performed in less intensive and less costly settings, such as ASCs and outpatient departments. ASC prospective payment system (ASCPPS) rates are frequently lower than outpatient prospective payment system (OPPS) rates, resulting in savings for Medicare.

Both the OPPS and ASCPPS must be budget neutral. Congress incorporated budget neutrality into these payment systems to ensure that total Medicare payments would not increase or decrease because of fluctuations within the systems themselves, other than the yearly adjustment for inflation.

WHAT WE FOUND

Medicare saved almost $7 billion during calendar years (CYs) 2007 through 2011 and could potentially save $12 billion from CYs 2012 through 2017 because ASC rates are frequently lower than outpatient department rates for surgical procedures. In addition, Medicare could generate savings of as much as $15 billion for CYs 2012 through 2017 if CMS reduces outpatient department payment rates for ASC-approved procedures to ASC payment levels for procedures performed on beneficiaries with low-risk and no-risk clinical needs.

Beneficiaries would also save through reduced cost sharing. Beneficiaries saved approximately $2 billion during CYs 2007 through 2011 and could potentially save an additional $3 billion for the next 6 years because the ASC rates are frequently lower than outpatient department rates. In addition, beneficiaries could potentially save as much as $2 billion to $4 billion more during the 6 years through CY 2017 if CMS reduces outpatient department payment rates for ASC-approved procedures to ASC payment levels.

We recognize that not all procedures can be performed in an ASC because a procedure might pose a significant safety risk to the patient. To account for this, we obtained patient-risk statistics from the Agency for Healthcare Research and Quality. The risk statistics showed that 33 percent of hospital patients 65 and older were considered to have no-risk medical profiles and an additional 35 percent were considered to be at low risk for procedures performed at an ASC. In total, 68 percent of patients had either low- or no-risk medical profiles. We used these risk profiles to estimate the range of potential savings to be between $7 billion and $15 billion for Medicare for CYs 2012 through 2017.

WHAT WE RECOMMEND

We recommend that CMS:

- seek legislation that would exempt the reduced expenditures as a result of lower OPPS payment rates from budget neutrality adjustments for ASC-approved procedures.

If Congress passes the budget-neutrality exemption for the reduced expenditures, we recommend that CMS take the following actions, which we estimated could save as much as $15 billion from CYs 2012 through 2017:

- reduce OPPS payment rates for ASC-approved procedures on beneficiaries with no-risk or low-risk clinical needs in outpatient departments and then

- develop and implement a payment strategy in which outpatient departments would continue to receive the standard OPPS payment rate for ASC-approved procedures that must be provided in an outpatient department because of a beneficiary's individual clinical needs.

CMS COMMENTS AND OUR RESPONSE

In written comments on our draft report, CMS did not concur with our recommendations. CMS stated that adopting the recommendations would require legislation and that such a proposal is not currently included in the President's Budget. CMS also noted that the recommended changes "…may raise circularity concerns with respect to the rate calculation process" because most ASC payment rates are based on the OPPS payment rates that we are recommending that CMS reduce and that we did not provide specific clinical criteria to distinguish patients' risk levels.

We continue to recommend that CMS draft, and submit for review, a legislative proposal that would exempt the reduced expenditures as a result of lower OPPS payment rates from budget

neutrality adjustments for consideration for inclusion in future budget and legislative agendas. As part of the process for developing the President's Budget, CMS identifies program vulnerabilities and offers solutions for addressing them. CMS has the authority to develop legislative proposals for Medicare and has historically addressed some OIG recommendations to seek legislative change by developing legislative proposals for possible inclusion in the President's budget and legislative program. Safeguarding programs from fraud, waste, and abuse is an ongoing program management responsibility and some issues may require legislation to address. We look forward to CMS's final management decision in light of this clarification of the intent of our recommendations.

Also, we agree that we did not provide specific clinical criteria to distinguish patients' risk levels and that, depending on the method used to implement our recommendations, circularity concerns may arise. However, that does not prevent implementation of our recommendations. CMS is in the best position to determine how to assess a patient's risk and to develop a payment strategy that would reduce OPPS payments for no- and low-risk patients without disrupting the current payment methodologies. Considering the potential savings identified in our report, we maintain that CMS should take the necessary steps to implement our recommendations.

TABLE OF CONTENTS

INTRODUCTION

WHY WE DID THIS REVIEW

Medicare covers many outpatient surgical procedures commonly performed in both hospital outpatient departments (outpatient departments) and in ambulatory surgical centers (ASCs). Medicare ASC payment rates are frequently lower than outpatient department payment rates. Thus Medicare generally saves when outpatient surgical procedures that do not pose significant risk to patients are performed in an ASC instead of an outpatient department. Our review quantifies the impact of this payment differential on aggregate Medicare expenditures for outpatient surgical procedures in the ASC setting as compared with outpatient departments. We completed this review in response to a congressional request, which asked us to assess the impact on total Medicare expenditures of providing surgical services in an ASC as opposed to other outpatient settings.

OBJECTIVES

Our objectives were to determine how much Medicare (1) has saved as a result of procedures being performed in ASCs instead of outpatient departments and (2) could save if payment rates for the outpatient departments were reduced to the same level as ASC payment rates.

BACKGROUND

How the Hospital Outpatient Prospective Payment System Works

Medicare beneficiaries receive a wide range of services in outpatient departments, from injections to complex procedures that require anesthesia. With changes in technology and medical practices, services traditionally provided in inpatient settings are more frequently provided in outpatient settings such as outpatient departments. In 2011, approximately 4,800 hospitals nationwide provided inpatient and outpatient services reimbursed by Medicare.

The Centers for Medicare & Medicaid Services (CMS) uses the hospital Outpatient Prospective Payment System (OPPS) to pay outpatient departments for designated Medicare Part B services furnished to hospital outpatients.[1] The services are identified by Healthcare Common Procedure Coding System (HCPCS) codes. CMS classifies services into ambulatory payment classifications (APCs) on the basis of clinical and resource use similarity. All services in an APC have the same payment rate.

CMS determines the payment rate for each outpatient department service by multiplying the relative weight for the service's APC by an OPPS conversion factor. The relative weight for an APC measures the resource requirements of the service and is based on the median cost of services and procedures in that APC. The purpose of the conversion factor is to translate relative weights into dollar amounts. The OPPS conversion factor is updated annually for inflation using

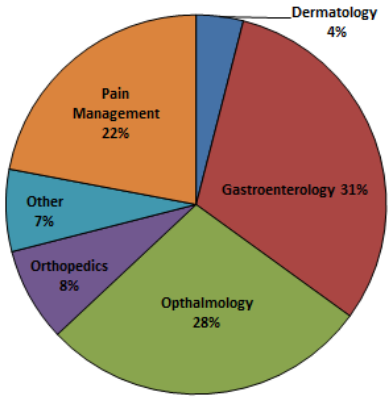
[1] 42 CFR § 419.2(a). See also, Social Security Act (the Act), §§ 1833(t)(1)(A) and (t)(1)(B)(i).

the hospital market basket price index (HMB).[2] In addition, the OPPS conversion factor is reduced by the Multifactor Productivity (MFP)[3] adjustment for 2012 and subsequent years[4] and by an additional adjustment for 2010 through 2019.[5]

How CMS Determines Payment Rates for Each Ambulatory Surgical Center Service

ASCs provide surgical services to patients who do not require an overnight stay. In 1982, Medicare began covering services provided in ASCs because CMS recognized that some surgical services provided on an inpatient basis could be safely performed in less intensive and less costly settings. In 2011, there were approximately 5,300 Medicare-certified ASCs nationwide. The most common types of surgical services performed in ASCs are presented in Figure 1.[6]

Figure 1: Medicare Case Volume by Specialty 2010



The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) required CMS to implement a revised ASC payment system. As a result, effective January 1, 2008, CMS implemented the ASC Prospective Payment System (ASCPPS) based on the OPPS, as recommended in the Government Accountability Office (GAO) report mandated by Congress.[7] The revised ASCPPS rate setting methodology continued to result in ASC payment rates that were frequently less than OPPS payment rates for the same procedure. With certain exceptions, the calendar year (CY) 2008 ASC payment rates were about 67 percent of the corresponding OPPS payment rates, which reflects the lower cost of furnishing services in the ASC setting.

CMS determines the payment rate for each ASC service by multiplying the relative weight for the service's APC by the ASC conversion factor (adjusted for geographic differences). The APC

[2] CMS defines a market basket as a fixed-weight index that "answers the question of how much more or less it would cost, at a later time, to purchase the same mix of goods and services that was purchased in a base period" (55 Fed. Reg. 35990, 36044 (Sept. 4, 1990)). Individual market baskets are produced for many of the Medicare payment systems to accurately measure anticipated price changes. The HMB index for 2012 was 3 percent (76 Fed. Reg. 74122, 74189 (Nov. 30, 2011)).

[3] The MFP is an adjustment to the price index that reflects a change in productivity (output) that cannot be accounted for by the change in inputs.

[4] The OPPS MFP adjustment for 2012 was 1 percent (76 Fed. Reg. 74122, 74189 (Nov. 30, 2011)).

[5] The additional adjustment for 2012 was 0.1 percent (the Act, §§1833(t)(3)(F)(ii) and (t)(3)(G)(ii)). See also, 42 CFR § 419.32(b)(1)(iv)(B)(3).

[6] ASC Association, *Ambulatory Surgery Centers: A Positive Trend in Health Care*, October 8, 2011.

[7] GAO, *Payment for Ambulatory Surgical Centers Should Be Based on the Hospital Outpatient Payment System* (GAO-07-86), November 2006.

relative weights for most procedures in the ASCPPS are the same as the relative weights in the OPPS. The ASC conversion factor also translates the relative weights into dollar amounts and was originally created as a percentage of the OPPS conversion factor; however, it is updated annually for inflation using the Consumer Price Index for All Urban Consumers[8] (CPI-U) and the ASCPPS MFP adjustment.[9]

Medicare Payments Must Remain Budget Neutral

Both the OPPS and ASCPPS must be budget neutral (the Act, § 1833). Congress incorporated budget neutrality into these payment systems to ensure that total Medicare payments would not increase because of fluctuations within the systems themselves, other than the yearly adjustment for inflation. Thus, the effects of an increase in the relative weights of some procedures would be offset by a decrease in the relative weights of other procedures.

The MMA required that the revised ASC payment system be budget neutral, similar to the OPPS. That is, the payment rates are intended to ensure that total Medicare expenditures under the revised payment methodology for ASCs will be approximately the same as the expenditures would have been in the same year without the revised ASC payment system.

Medicare Beneficiaries Share the Financial Responsibility for Procedures Performed

"Beneficiary cost sharing" is the Medicare beneficiary's share of the financial responsibility for the procedure performed. For ASC procedures provided on or after January 1, 2008, the beneficiary pays the lesser of "20 percent of the actual charge or 20 percent of the prospective payment amount . . . ." (42 CFR § 410.152(i)(2)). For procedures provided in outpatient departments, Medicare is transitioning to a standard Medicare 20 percent coinsurance rate by requiring the beneficiary to pay the greater of 20 percent of the APC payment or, for certain services, a set payment amount which cannot exceed 40 percent of the APC payment (42 CFR §§ 419.40–419.42)).[10] When the beneficiary's clinical needs allow for a procedure to be performed in an ASC, the beneficiary could choose to do so and benefit because the payment rates are usually lower than in an outpatient department. If the procedure is performed in an outpatient department, both the Medicare payment and the beneficiary cost-sharing amount are generally higher.

[8] The Bureau of Labor Statistics' Web site states "the CPI-U represents changes in prices of all goods and services purchased for consumption by urban households" and covers approximately 87 percent of the total population (Bureau of Labor Statistics, *Overview.* – Accessed on July 25, 2013). For the purposes of the ASC conversion factor, the CPI-U for 2012 was 2.7 percent (76 Fed. Reg. 74122, 74450 (Nov. 30, 2011)).

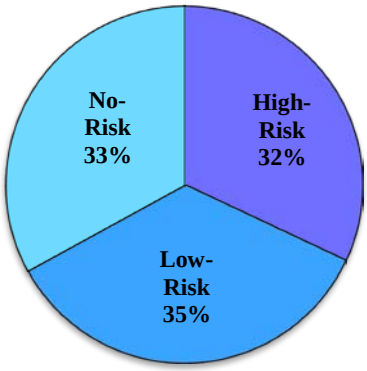
[9] The ASCPPS MFP adjustment for 2012 was 1.1 percent (76 Fed. Reg. 74122, 74450 (Nov. 30, 2011)).

[10] As the total APC payment increases each year, the set payment amount will become a smaller portion of the total payment until it represents 20 percent of the total payment. CMS estimated that, for CY 2013, the overall beneficiary share of total payments for Medicare-covered hospital outpatient services would be about 21.6 percent. (CMS, *Proposed 2013 Policy, Payment Changes for Hospital Outpatient Departments, Ambulatory Surgical Centers, Inpatient Rehabilitat* [sic], fact sheet, July 6, 2012.).

Ambulatory Surgical Center-Approved Procedures Do Not Pose a Significant Safety Risk to Most Patients

In selecting covered surgical procedures payable under ASCPPS, the Secretary of Health and Human Services (the Secretary) must select only those procedures that "would not be expected to pose a significant safety risk to a Medicare beneficiary when performed in an ASC . . . ." (42 CFR § 416.166(b)). However, "[t]he decision regarding the most appropriate care setting [e.g., an ASC or outpatient department] for a given surgical procedure is made by the physician based on the beneficiary's individual clinical needs and preferences."[11] Accordingly, a physician may determine that a covered procedure cannot be performed in an ASC because of a specific patient's clinical needs. To account for these procedures in our report, we obtained statistics from the Agency for Healthcare Research and Quality (AHRQ) derived from 3,072,311 CY 2010 health records for patients 65 or older. AHRQ statistics showed that approximately 32 percent of these patients were considered to have high-risk medical profiles and 68 percent of patients had no-risk (33 percent) or low-risk (35 percent) medical profiles. These statistics are displayed in Figure 2. See Appendix A for a detailed explanation of AHRQ's patient-risk statistics. For purposes of this report, we accounted for patients whose clinical needs would prevent them from having covered surgical procedures in ASCs by excluding a percentage of patients with high-risk medical profiles (32 percent) from our estimates.

Figure 2: AHRQ Patient Medical Profile Risk Analysis



Prior OIG Work Identified a Payment Differential

In 2003, the Office of Inspector General (OIG) issued a report[12] stating that a payment differential existed between ASC and outpatient department Medicare payment rates, as identified in the OPPS and ASCPPS fee schedules. For 66 percent of the procedure codes examined for CY 2001, outpatient department payment rates were higher than ASC payment rates, with a median difference of $282.33. For the remaining 34 percent of procedure codes reviewed, ASC payment rates were higher than outpatient department payment rates, with a median difference of $135.78. We estimated Medicare paid $1.1 billion more for services provided in outpatient departments during CY 2001 than it would have paid if outpatient department payment rates equaled ASC payment rates.

[11] *Medicare Claims Processing Manual*, Pub. No. 100-04, ch. 14, § 20.1.

[12] *Payment for Procedures in Outpatient Departments and Ambulatory Surgical Centers* (OEI-05-00-00340, issued Jan. 2003).

HOW WE CONDUCTED THIS REVIEW

We limited our review to Medicare Part B payments to ASCs and outpatient departments for ASC-approved procedures performed during CYs 2007 through 2011. From a total of approximately $12.6 billion that Medicare paid to ASCs for procedures performed during that period, we reviewed claims that included 413 ASC-approved HCPCS codes (representing 96 percent of procedures performed in ASCs and 95 percent of Medicare payments at ASCs). We selected the 413 HCPCS codes that during any 1 year of our audit period: (1) were performed at ASCs at least 1,000 times or (2) for which Medicare reimbursed at least $1 million. We compared the average Medicare payments for the selected HCPCS codes at ASCs and outpatient departments to identify the payment differential during the review period.

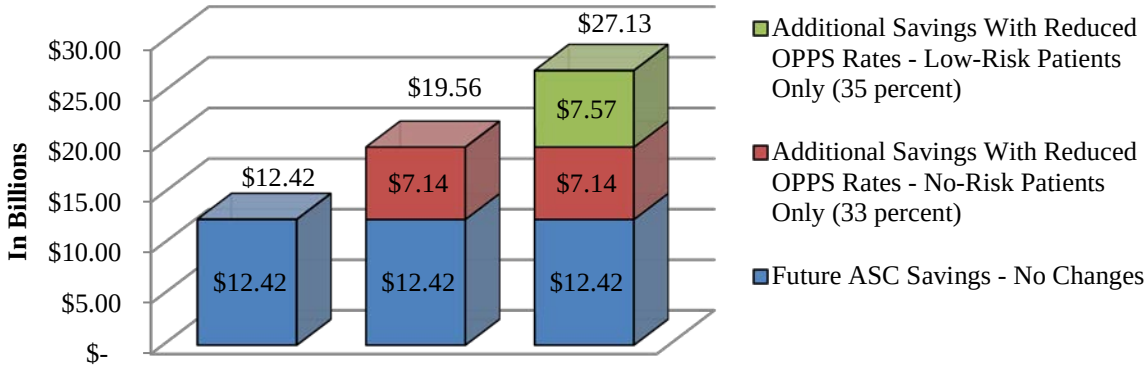
We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A gives details on AHRQ patient-risk data; Appendix B lists the Federal requirements related to ASCs, outpatient departments, and the respective payment systems; and Appendix C provides the details of our audit scope and methodology. Appendix D shows our mathematical calculation methodology, and Appendix E has the results of our calculations.

FINDINGS

Medicare saved almost $7 billion during CYs 2007 through 2011 and could potentially save $12 billion during CYs 2012 through 2017 because the ASC rates are frequently lower than outpatient department rates for outpatient surgical procedures performed at ASCs. Medicare could generate additional savings of as much as $15 billion if CMS reduces outpatient department payment rates for ASC-approved procedures to ASC payment levels for procedures performed on beneficiaries with low-risk and no-risk clinical needs. Figure 3 summarizes the CYs 2012 through 2017 Medicare savings.

Figure 3: Medicare Savings CYs 2012-2017



These Medicare figures do not include savings to the beneficiary for cost sharing. Beneficiaries saved approximately $2 billion during CYs 2007 through 2011. During CYs 2012 through 2017, beneficiaries could potentially save $3 billion because the ASC rates are frequently lower than outpatient department rates for outpatient surgical procedures performed at ASCs. Beneficiaries could potentially save an additional $2 billion to $4 billion during CYs 2012 through 2017 if CMS reduces outpatient department payment rates for ASC-approved procedures to ASC payment levels.

MEDICARE EXPERIENCED SAVINGS BECAUSE OF THE PAYMENT DIFFERENTIAL

The difference between ASC and outpatient department payment rates saved Medicare almost $7 billion and beneficiaries an additional $2 billion during CYs 2007 through 2011. For 96 percent of the HCPCS codes examined, ASC average payments were lower than outpatient department average payments with the largest median[13] difference of $364.90 occurring in 2009. Table 1 summarizes the median differences of average payments by year for selected HCPCS codes.

Table 1: Median Differences Between Average ASCPPS and OPPS Payments for Selected HCPCS

2007	2008	2009	2010	2011
$294.13	$341.95	$364.90	$348.22	$363.15

Assuming that utilization does not change for ASCs and outpatient departments during CYs 2012 through 2017 from that of CY 2011, Medicare will save approximately $12 billion because of the payment differential. CMS does not need to make any changes, nor do ASCs have to perform any additional procedures, for these savings to occur. Estimated beneficiary savings of approximately $3 billion are in addition to these estimated Medicare savings.

MEDICARE COULD GAIN ADDITIONAL SAVINGS THROUGH LEGISLATIVE CHANGE FOR LOWER OUTPATIENT PROSPECTIVE PAYMENT SYSTEM PAYMENT RATES

Medicare and its beneficiaries could save more if CMS lowered OPPS payment rates for ASC-approved procedures to the level of ASC payment rates. However without legislative change, budget neutrality required by section 1833(t)(9)(B) of the Act would negate these savings. The budget neutrality adjustment applied to the OPPS rate setting methodology causes any decreases in relative weights to be offset by increases in other relative weights. In effect, lowered rates for some procedures would result in higher rates for others. For Medicare to realize these additional savings long-term, legislation must allow the OPPS rates for ASC-approved procedures to be determined in a non-budget-neutral manner (i.e., outside of section 1833(t)(9)(B) of the Act).

[13] The average differences included several outliers and anomalies. Therefore, we based our analysis on the median rather than the mean.

When calculating potential savings, we assumed that CMS would lower OPPS rates for ASC-approved procedures to at least equal that of ASCPPS rates, when, in fact, CMS could lower rates to any level it deemed reasonable. We calculated the potential savings for CYs 2012 through 2017 by using (1) CY 2011 utilization data, (2) the estimated increase in OPPS payment rates based on changes in the HMB price index and related MFP adjustment, and (3) the estimated increase in the ASCPPS payment rates on the basis of changes in the CPI-U price index and related MFP adjustment.

With legislative change and reduced OPPS rates for ASC-approved procedures, Medicare could generate potential savings of as much as $15 billion during these years for beneficiaries without high-risk medical profiles. We recognize that not all beneficiaries can receive services in an ASC because of the beneficiaries' clinical needs. To account for these beneficiaries, we used AHRQ statistics to exclude procedures for a percentage of beneficiaries with high-risk medical profiles (32 percent of patients) and reduced our total estimated savings to a range of approximately $7 billion to $15 billion. These savings are stated as a range to present potential savings of $7 billion for those procedures performed on beneficiaries with only no-risk medical profiles (33 percent of patients), to potential savings of $15 billion for those procedures performed on beneficiaries with only low- and no-risk medical profiles (68 percent of patients). In addition, these beneficiaries could potentially save an additional $2 billion to $4 billion during these years.

We recognize that when procedures must be performed in an outpatient department because of the beneficiary's clinical needs, higher costs would be possible. As such, these services could be reimbursed at the standard OPPS rate.[14]

CONCLUSION

As a result of the payment differential, Medicare saved almost $7 billion and beneficiaries saved an additional $2 billion during CYs 2007 through 2011. Also, Medicare and beneficiaries could save an additional $12 billion and $3 billion, respectively, during CYs 2012 through 2017. We estimated that Medicare could save as much as $15 billion more and beneficiaries could potentially save as much as $4 billion more if CMS changes the way it pays outpatient departments for certain ASC-approved procedures.

RECOMMENDATIONS

We recommend that CMS:

- seek legislation that would exempt the reduced expenditures as a result of lower OPPS payment rates from budget neutrality adjustments for ASC-approved procedures.

[14] However, if Congress makes the recommended legislative change and CMS reduces OPPS rates for ASC-approved procedures, we do not intend for CMS to use AHRQ statistics to implement the reduced OPPS rates or any necessary exceptions to those rates.

If Congress passes the budget-neutrality exemption for the reduced expenditures, we recommend that CMS take the following actions, which we estimated could save as much as $15 billion for CYs 2012 through 2017:

- reduce OPPS payment rates for ASC-approved procedures on beneficiaries with no-risk or low-risk clinical needs in outpatient departments and then

- develop and implement a payment strategy in which outpatient departments would continue to receive the standard OPPS payment rate for ASC-approved procedures that must be provided in an outpatient department because of a beneficiary's individual clinical needs.

CMS COMMENTS

In written comments on our draft report, CMS did not concur with our recommendations. CMS stated that adopting the recommendations would require legislation and that such a proposal is not currently included in the President's Budget. CMS also noted that the recommended changes "…may raise circularity concerns with respect to the rate calculation process" because most ASC payment rates are based on the OPPS payment rates that we are recommending that CMS reduce and that OIG did not provide specific clinical criteria to distinguish patients' risk levels. CMS's comments are included in their entirety as Appendix F.

OFFICE OF INSPECTOR GENERAL RESPONSE

We continue to recommend that CMS draft, and submit for review, a legislative proposal that would exempt the reduced expenditures as a result of lower OPPS payment rates from budget neutrality adjustments for consideration for inclusion in future budget and legislative agendas. As part of the process for developing the President's Budget, CMS identifies program vulnerabilities and offers solutions for addressing them. CMS has the authority to develop legislative proposals for Medicare and has historically addressed some OIG recommendations to seek legislative change by developing legislative proposals for possible inclusion in the President's budget and legislative program. Safeguarding programs from fraud, waste, and abuse is an ongoing program management responsibility and some issues may require legislation to address. We look forward to CMS's final management decision in light of this clarification of the intent of our recommendations.

Also, we agree that we did not provide specific clinical criteria to distinguish patients' risk levels and that, depending on the method used to implement our recommendations, circularity concerns may arise. However, that does not prevent implementation of our recommendations. CMS is in the best position to determine how to assess a patient's risk and to develop a payment strategy that would reduce OPPS payments for no- and low-risk patients without disrupting the current payment methodologies. Considering the potential savings identified in our report, we maintain that CMS should take the necessary steps to implement our recommendations.

APPENDIX A: CONSIDERING PATIENT RISK USING AGENCY FOR HEALTHCARE RESEARCH AND QUALITY DATA

To account for patient risk, OIG obtained statistics from the Healthcare Cost and Utilization Project (HCUP).

The HCUP is a family of health care databases and related software tools and products developed through a Federal-State-industry partnership and sponsored by AHRQ. HCUP includes the largest collection of hospital care data in the United States, with encounter-level information beginning in 1988. HCUP databases bring together the data collection efforts of State data organizations, hospital associations, private data organizations, and the Federal Government to create a national information resource of patient-level health care data.

AHRQ officials provided us with research data from a study AHRQ did of the HCUP exploring short-stay (less than 2 days) surgeries performed for adults 65 and older with common risk factors (defined below) using CY 2010 data from 27 State data organizations that participate in HCUP State Inpatient Databases and State Ambulatory Surgery Databases. The organizations came from these States: California, Colorado, Connecticut, Florida, Georgia, Hawaii, Iowa, Illinois, Indiana, Kansas, Kentucky, Maryland, Michigan, Minnesota, Missouri, North Carolina, Nebraska, New Jersey, New York, Ohio, Oklahoma, Oregon, South Carolina, South Dakota, Tennessee, Vermont, and Wisconsin.

AHRQ officials used a population of 3,072,311 HCUP records during CY 2010 for patients meeting the following criteria:

- 65 or older,
- treated and discharged at community nonrehabilitation hospitals,
- with inpatient stays of 2 days or less, and
- whose patient records included at least one diagnosis or procedure code fitting the HCUP narrow definition of "surgery."

Patient-Risk Level Defined

AHRQ officials identified patients as high risk, low risk, or no risk on the basis of the following risk factor conditions: age 80 and older, cancer, diabetes, mental health and substance abuse disorders, nervous system disorder, heart disease, asthma/chronic obstructive pulmonary disease, renal failure, arthritis, or obesity. A high-risk patient was defined as having two or more of these risk factor conditions. A low-risk patient was defined as having one of these risk factor conditions. A no-risk patient was defined as having none of these risk factor conditions. AHRQ officials defined these risk factors by grouping chronic diagnosis codes and then identifying records of patients with discharges including these diagnosis codes.

Agency for Healthcare Research and Quality Data Results

Of the 3,072,311 patient-discharge records in the population, 32 percent included two or more risk factors and were considered high risk. Thirty-five percent included one risk factor and were considered as having low risk. The remaining 33 percent were considered as having no risk because the record did not contain any of the selected risk factors. Table 2 summarizes these patient risk level results.

Table 2: Patient-Risk Levels

Risk Factors	Percent of Total	Low- and No-Risk	No-Risk
No-Risk (0 factors)	33%	33%	33%
Low-Risk (1 factor)	35%	35%	
High-Risk (2 or more factors)	32%		
Total	**100%**	**68%**	**33%**

These results show that approximately 32 percent of patients have a high-risk medical profile and that the remaining 68 percent of patients have no-risk (33 percent) or low-risk (35 percent) medical profiles.

APPENDIX B: FEDERAL REQUIREMENTS

FEDERAL REQUIREMENTS FOR AMBULATORY SURGICAL CENTER-APPROVED PROCEDURES

Federal regulations at 42 CFR § 416.166 state that surgical procedures in an ASC that are covered by Medicare (ASC-approved) must include only outpatient surgeries that CMS has determined do not pose a significant safety risk to the patient when furnished in an ASC, are not expected to require active medical monitoring at midnight following the procedure (i.e., an overnight stay), and are separately paid under OPPS. Excluded surgical procedures have the following characteristics:

(1) Generally result in extensive blood loss;

(2) Require major or prolonged invasion of body cavities;

(3) Directly involve major blood vessels;

(4) Are generally emergent or life threatening in nature;

(5) Commonly require systemic thrombolytic therapy;

(6) Are designated as requiring inpatient care under § 419.22(n);

(7) Can only be reported using a CPT [common procedural terminology] unlisted surgical procedure code; or

(8) Are otherwise excluded under § 411.15.

FEDERAL REQUIREMENTS FOR THE OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

Sections 1833(t)(1)(A) and (t)(1)(B)(i) of the Act require the establishment of a prospective payment system for covered outpatient department services. Covered outpatient department services are designated by the Secretary. Section 419.2(a) of 42 CFR states the services are identified by HCPCS codes.

The basic methodology for determining OPPS payment rates is set forth in 42 CFR part 419 subpart C. Section 419.31(a) states that CMS classifies outpatient services and procedures into APC groups on the basis of clinical and resource use similarity. Section 419.32(c) defines the OPPS payment rate as the product of the OPPS conversion factor and APC relative weight, and section 419.32(b) states that the OPPS conversion factor is updated yearly partly on the basis of the HMB percentage increase. Section 419.32(b)(1)(iv)(B)(3) states that the percentage increase determined under (b)(1)(IV)(a) is reduced by the following for the specified year and for CY 2012: a multifactor adjustment and a 0.1 percentage point. The APC relative weights are determined by a process explained in section 419.31(b).

Section 1833(t)(3)(F)(i) of the Act requires that the OPPS increase factor be reduced by the productivity adjustment for 2012 and subsequent years. Sections (t)(3)(F)(ii) and (t)(3)(G)(ii) discuss additional adjustments for 2010 through 2019.

Section 419.41(b) of 42 CFR states that, each year, CMS calculates the Medicare payment percentage for each APC group on the basis of each group's unadjusted copayment amount and its payment rate adjusted by the conversion factor. For each APC group, the beneficiary's coinsurance percentage is the greater of 20 percent or the ratio of the APC group unadjusted copayment amount to the APC group payment rate (42 CFR § 419.40(b)(1)). However, the coinsurance percentage cannot exceed 40 percent (42 CFR § 419.41(c)(4)(iii)). In addition, the copayment amount cannot exceed the amount of the inpatient hospital deductible (42 CFR § 419.41(c)(4)(i)).

FEDERAL REQUIREMENTS FOR THE AMBULATORY SURGICAL CENTER PROSPECTIVE PAYMENT SYSTEM

Section 626(b)(2) of the MMA required CMS to revise the ASC payment system no later than January 1, 2008. Subparagraph (D) of section 1833(i)(2) of the Act, as added by the MMA and later amended by section 5103 of the Deficit Reduction Act of 2005, reads as follows:

> (D)(i) Taking into account the recommendations in the report under section 626(d) of Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the Secretary shall implement a revised payment system for payment of surgical services furnished in ambulatory surgical centers.
>
> (ii) In the year the system described in clause (i) is implemented, such system shall be designed to result in the same aggregate amount of expenditures for such services as would be made if this subparagraph did not apply, as estimated by the Secretary and taking into account reduced expenditures that would apply if subparagraph (E) were to continue to apply, as estimated by the Secretary.
>
> (iii) The Secretary shall implement the system described in clause (i) for periods in a manner so that it is first effective beginning on or after January 1, 2006, and not later than January 1, 2008.

The ASC rate setting methodology under the revised ASC payment system is set forth in 42 CFR § 416 subpart F. Section 416.167(a) includes the requirement that covered surgical procedures and covered ancillary services are identified by codes established under the HCPCS as the unit of payment. Section 416.167(b)(1) states that ASC-covered surgical procedures are classified using the APC groups described in section 419.31. Section 416.171 describes the determination of payment rates. Specifically, section 416.171(a) states the standard methodology is to calculate the product of the ASC conversion factor and the APC relative payment weight. Section 416.171(a)(2)(ii) states that, for CY 2010 and subsequent CYs, the ASC conversion factor is updated using the CPI-U. The APC relative weights are determined by a process explained in section 416.167(b).

Section 1833(i)(2)(D)(v) of the Act requires that, effective for CY 2011 and subsequent years, any annual update under the ASC payment system be reduced by a productivity adjustment.

Charges for services covered under the ASCPPS beyond the 80 percent Medicare covers are the beneficiary's responsibility. For ASC services furnished on or after January 1, 2008, "Medicare Part B pays the lesser of 80 percent of the actual charge or 80 percent of the prospective payment amount, geographically adjusted, if applicable ..." (42 CFR § 410.152(i)(2)). Therefore, the beneficiary's financial responsibility "is 20 percent of the actual charge or 20 percent of the prospective payment amount, geographically adjusted, if applicable."

FEDERAL REQUIREMENTS FOR BUDGET NEUTRALITY

Section 1833(t)(9)(B) of the Act regarding the OPPS states that "[i]f the Secretary makes adjustments under subparagraph (A), then the adjustments for a year may not cause the estimated amount of expenditures under this part for the year to increase or decrease from the estimated amount of expenditures under this part that would have been made if the adjustments had not been made."

Section 1833(i)(2)(D) of the Act regarding the ASCPPS states that "a revised payment system for payment of surgical services furnished in ambulatory surgical centers … shall be designed to result in the same aggregate amount of expenditures for such services as would be made if this subparagraph did not apply, as estimated by the Secretary and taking into account reduced expenditures that would apply if subparagraph (E) were to continue to apply, as estimated by the Secretary."

In the Final Rule, CMS-1517-F (72 Fed. Reg. 42470, 42533 (Aug. 2, 2007)), CMS stated that it will "update the ASC relative payment weights in the revised ASC payment system each year using the national OPPS relative payment weights for that same calendar year and uniformly scale the ASC relative payment weights for each update year to make them budget neutral."

APPENDIX C: AUDIT SCOPE AND METHODOLOGY

SCOPE

We limited our review to Medicare Part B payments to ASCs and outpatient departments for ASC-approved procedures paid for during CYs 2007 through 2011. We identified average Medicare payments and the numbers of procedures performed in ASCs and outpatient departments. We limited our review to only those HCPCS codes during any given year (1) that were performed at ASCs at least 1,000 times or (2) for which Medicare reimbursed ASCs at least $1 million. The selected sample was 413 HCPCS codes during the period under review and represents 96 percent of procedures performed and 95 percent of Medicare payments at ASCs.

Using this information, we compared the average Medicare payments for the selected HCPCS codes at ASCs and outpatient departments to identify the payment differential during the review period. We determined the amount that could have been saved had all HCPCS in our sample been performed at ASCs during this period. Furthermore, we calculated the potential Medicare savings from CYs 2012 through 2017 using CY 2011 utilization and payment rates. We did not adjust our calculations to include changes in utilization; however, we did adjust for changes in payment rates using the annual HMB and CPI-U price index updates and the MFP adjustments.

We used CY 2011 payment rates because 2011 was the first year that CMS calculated ASC payment rates using only the revised methodology established under 42 CFR § 416 subpart F. Federal regulations required CMS to implement the ASCPPS using a transitional period during CYs 2008 through 2010 (42 CFR § 416.171(c)). In addition, CY 2011 was the most current year of data available at the time.

We did not review the overall internal control structure of CMS as it relates to the Medicare payment system for ASCPPS and OPPS. Rather, we limited our internal control review to those controls that related to the objective of our audit.

We conducted fieldwork at the CMS Central Office in Baltimore, Maryland, from February through November, 2012.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- held discussions with CMS officials to identify and gain an understanding of policies and procedures related to the ambulatory surgical services and hospital outpatient department programs;
- obtained Medicare utilization and payment data from the CMS's National Claims History File by HCPCS code for ambulatory surgical services provided in ASCs and outpatient departments for the period January 1, 2007, through December 31, 2011;

- obtained CYs 2013 through 2017 estimated HMB and CPI-U price index updates and respective MFP adjustments from CMS's Office of the Actuary (OACT);

- identified total Medicare expenditures related to all procedures performed in ASC and outpatient department settings;

- created a sampling frame of 12,182 HCPCS codes that were associated with 3.4 billion procedures performed totaling $234 billion for the 5-year period under review which included:

    - 35 million procedures reimbursed at ASCs for Medicare payments totaling $13 billion; and

    - 3.4 billion procedures reimbursed at outpatient departments for Medicare payments totaling $221 billion;

- selected from the sampling frame a judgmental sample of 413 HCPCS codes:[15]

    - that were performed at ASCs at least 1,000 times during any 1 year[16] or

    - for which Medicare reimbursed ASCs at least $1 million during any 1 year;

- calculated ASCPPS payments as a percentage of OPPS payments for each year and for the combined 5-year audit period;

- calculated the average Medicare payment per HCPCS code in both the ASC and outpatient department settings;

- calculated the difference between average Medicare payments for procedures performed in ASCs and average Medicare payments for the same procedures performed in outpatient departments;

- calculated Medicare savings for each year in our audit period by multiplying utilization by the difference between average ASC and outpatient department Medicare payments;

- calculated future potential savings using CY 2011 utilization data and the difference between the average ASC and outpatient department payments updated each year for estimated changes in the CPI-U and HMB price indexes and the MFP adjustments;

[15] These 413 HCPCS codes related to 96 percent of procedures performed and 95 percent of Medicare reimbursements during the audit period. Specifically, Medicare reimbursed providers $12,089,489,909 for 33,767,338 procedures performed at ASCs and $35,732,207,819 for 56,806,824 of the same procedures performed at outpatient departments during our audit period.

[16] The selection criteria specify that the condition need only be met during any 1 year, so many HCPCS codes may not meet the criteria during all years.

- obtained AHRQ statistical data on patient risk and applied the data to our findings (Appendix B);

- identified that 20 percent is a conservative and approximate amount of beneficiary cost sharing and applied the percentage to our findings;

- determined the effects of budget neutrality on changes in utilization and payment rates; and

- discussed the results of our review with CMS officials.

See Appendix D for our mathematical calculation methodology and Appendix E for our sample results and potential savings.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX D: MATHEMATICAL CALCULATION METHODOLOGY

MEDICARE SAVINGS FOR 2007 THROUGH 2011

To determine the savings Medicare experienced during CYs 2007 through 2011 because of the payment differential, we calculated the difference between the average Medicare payments in ASCs and outpatient departments for each HCPCS code in each year, multiplied the difference in average payment by the ASC utilization, and totaled each year's results.

POTENTIAL MEDICARE SAVINGS FOR 2012 THROUGH 2017

To estimate the savings Medicare could experience during CYs 2012 through 2017 because of the payment differential, we used CY 2011 ASC utilization and estimated increases in payment rates using HMB and CPI-U estimates and MFP adjustments. We calculated the difference between the projected average Medicare payments in ASCs and outpatient departments for each HCPCS code during the timeframe.

POTENTIAL MEDICARE SAVINGS FOR 2012 THROUGH 2017 BY LOWERING OUTPATIENT PROSPECTIVE PAYMENT SYSTEM PAYMENT RATES TO EQUAL AMBULATORY SURGICAL CENTER PROSPECTIVE PAYMENT SYSTEM RATES

To estimate the potential Medicare savings for CYs 2012 through 2017 if CMS lowered OPPS rates to equal ASCPPS rates, we used (1) CY 2011 outpatient department utilization, (2) the estimated increase in OPPS payment rates based on changes in the HMB price index and related MFP adjustment, and (3) the estimated increase in the ASCPPS payment rates based on changes in the CPI-U price index and related MFP adjustment. We did not estimate for increases in utilization. We calculated the difference between the estimated average Medicare payments in ASCs and outpatient departments for each HCPCS code, multiplied that difference by the 2011 utilization amounts, summed the total for all HCPCS, and summed the yearly totals for CYs 2012 through 2017.

We adjusted the estimated total savings to reflect a range of more conservative savings for procedures that cannot be performed in an ASC because of patient risk by multiplying the estimated savings by 33 percent and 68 percent.

APPENDIX E: POTENTIAL SAVINGS FOR THE SELECTED SAMPLE

Table 3: Results

Year	HCPCS Codes	ASCs		Outpatient Departments	
		Utilization	Reimbursements	Utilization	Reimbursements
2007	335	6,183,115	$2,234,435,661	11,294,362	$5,261,148,371
2008	389	6,715,120	2,344,484,318	11,633,361	6,528,775,831
2009	386	7,037,850	2,434,219,342	12,380,024	7,434,935,153
2010	390	7,267,716	2,510,848,058	10,463,074	7,943,756,809
2011	392	6,563,537	2,565,502,530	11,036,003	8,563,591,655
Total	**413**[17]	**33,767,338**	**$12,089,489,909**	**56,806,824**	**$35,732,207,819**

Table 4: Estimated Medicare Savings for CYs 2007 Through 2011

Year	Estimated Savings
2007	$ 795,652,581
2008	1,084,518,402
2009	1,448,920,045
2010	1,648,016,920
2011	1,835,751,695
Total	**$6,812,859,643**

Table 5: Potential Medicare Savings for CYs 2012 Through 2017 If Utilization and Payment Rates Remain the Same

Year	Potential Savings
2012	$ 1,882,726,731
2013	1,952,384,520
2014	2,016,314,061
2015	2,097,978,560
2016	2,191,812,068
2017	2,280,568,191
Total	**$12,421,784,131**

[17] The total amount of HCPCS codes selected is not equal to the sum of all HCPCS performed from CYs 2007 through 2011. The selection criteria specify that the condition need only be met during any 1 year to be included in the sample.

Table 6: Additional Possible Medicare Savings for CYs 2012 Through 2017 by Lowering Outpatient Prospective Payment System Payment Rates To Equal Ambulatory Surgical Center Prospective Payment System Rates

Year	Savings Including 68% of the At-Risk Population	Savings Including 33% of the At-Risk Population
2012	$2,211,745,417	$1,073,347,042
2013	2,302,229,829	1,117,258,593
2014	2,382,881,818	1,156,398,529
2015	2,486,667,984	1,206,765,345
2016	2,606,478,140	1,264,908,509
2017	2,718,636,081	1,319,338,098
Total	**$14,708,639,269**	**$7,138,016,116**

APPENDIX F: CMS COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: DEC 13 2013

TO: Daniel R. Levinson
Inspector General

FROM: Marilyn Tavenner
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: Medicare and Beneficiaries Could Save Billions If CMS Reduces Hospital Outpatient Department Payment Rates for Ambulatory Surgical Center-Approved Procedures to Ambulatory Surgical Center Payment Rates (A-05-12-00020)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and respond to the above subject OIG draft. OIG stated that the objectives of its review were to determine how much Medicare--(1) Has saved as a result of procedures being performed in Ambulatory Surgical Centers (ASCs) instead of outpatient departments; and (2) Could save if payment rates for the outpatient departments were reduced to the same level as ASC payment rates. According to OIG, Medicare saved almost $7 billion during calendar years (CYs) 2007 through 2011 and could potentially save $12 billion from CYs 2012 through 2017 because ASC rates are frequently lower than outpatient department rates for surgical procedures. In addition, Medicare could generate savings of as much as $15 billion for CYs 2012 through 2017 if CMS reduces outpatient department payment rates for ASC-approved procedures to ASC payment levels for procedures performed on beneficiaries with low risk and no-risk clinical needs.

The OIG recommendations and the CMS response to those recommendations are discussed below.

OIG Recommendations

The OIG recommends that CMS seek legislation that would exempt the reduced expenditures as a result of lower outpatient perspective payment system (OPPS) payment rates from budget neutrality adjustments for ASC-approved procedures.

If Congress passes the budget-neutrality exemption for the reduced expenditures, OIG recommends that CMS take the following actions, which OIG estimated could save as much as $15 billion from CYs 2012 through 2017:

- Reduce OPPS payment rates for ASC-approved procedures on beneficiaries with no-risk or low-risk clinical needs in outpatient departments.

- Develop and implement a payment strategy in which outpatient departments would continue to receive the standard OPPS payment rate for ASC-approved procedures that must be provided in an outpatient department because of a beneficiary's individual clinical needs.

CMS Response

We do not concur with the recommendations. As OIG's recommendations indicate, adopting these recommendations would require legislation and such a proposal is not currently included in the President's Budget. We further note that most ASC payment rates are based on the OPPS relative payment weights and an ASC-specific conversion factor. Because most ASC rates are based on OPPS rates, OIG's recommendations may raise circularity concerns with the respect to the rate calculation process. Lastly, we note that OIG suggests no specific clinical criteria to distinguish patients that can be adequately treated in an ASC relative to the hospital outpatient setting that would be needed to act on these recommendations.

The CMS thanks OIG for their efforts on this issue and looks forward to working with OIG on this and other issues in the future.