

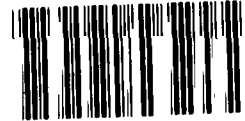


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HUMAN RESOURCES  
DIVISION

July 12, 1984

Carolyn K. Davis, Ph.D., Administrator  
Health Care Financing Administration  
Department of Health and Human Services



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Dear Dr. Davis:

**Subject: Payment Rates For Ambulatory Surgery Centers  
Are Higher Than Intended By The Health Care  
Financing Administration (GAO/HRD-84-67)**

The Omnibus Reconciliation Act of 1980 (Public Law 96-499) authorized payments under Medicare to ambulatory surgical centers (ASCs) to cover their operating costs. The amount of payments--called standard overhead amounts--was to be based on the Department of Health and Human Services' estimate of the costs generally incurred by ASCs in furnishing services in connection with ambulatory surgery. Also, the standard overhead amounts were to be set at a level that would assure that the Medicare cost of services in ASCs would be substantially less than the costs of the surgeries if performed on a hospital inpatient basis. Although the Health Care Financing Administration (HCFA) established the standard overhead amounts at levels that appear to be saving Medicare dollars, it set the amounts at higher levels than it intended. This resulted because HCFA based the payment amounts on charges without making an intended adjustment which would have reduced the charges to costs. Because of this, the payment amounts are 10 percent higher than intended by HCFA.

In addition, HCFA said when it established the ASC payment rates that the data used was quite limited and that it intended to revise the rates when better data was available. We believe that better data should now be available and that HCFA should begin the process of re-evaluating the rates.

PAYMENT RATES WERE  
BASED ON CHARGES, NOT COSTS

When the ASC benefit was enacted by the Congress, HCFA had little data on which to base payment rates for it. Therefore, HCFA sought information on ASCs through the Freestanding Ambulatory Surgery Association, a trade group representing ASCs, and other interested parties. HCFA obtained 35 charge schedules from ASCs and used these to compute national average charges for procedures performed in ASCs and to categorize procedures into 4 groups. HCFA's payment methodology called for reducing the charge-based amounts to cost-based amounts by applying an estimated national average cost-to-charge ratio of 90 percent.

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HCFA selected the 60th percentile of the average charges for the procedures in each group to be the group rate as its base for calculating ASC payment rates.

In a Federal Register notice of March 23, 1982, HCFA explained the selection of the 60th percentile charge as follows:

"In considering the appropriate percentile to select as the group rate, we examined centers' charges and potential Medicare reimbursement for the 35 most commonly furnished surgical procedures. We evaluated the effects of Medicare reimbursement at several alternative points. . . This analysis showed that at the 60th percentile, centers should recover 90.83 percent of their charges for the procedures evaluated. . . [Thus,] reimbursement at the 60th percentile of the group charges should reasonably approximate national average reasonable cost levels."

The 35 most commonly furnished procedures were identified through a survey of ASCs conducted by the Freestanding Ambulatory Surgery Association. HCFA estimated that these 35 procedures would account for about 80 percent of the surgeries performed on Medicare beneficiaries under the ambulatory surgery benefit.

HCFA adjusted charges to costs using the 90 percent cost-to-charge ratio in its analysis cited above; however, this adjustment was not made in calculating the final rates. As a result, the standard overhead rates for the 4 groups of procedures were set at a level that represents 111 percent of the level intended by the methodology.

When we asked the HCFA personnel who were involved in developing the standard overhead amounts why the 60th percentile charge was not adjusted by the cost-to-charge ratio, they told us that they believed that the 60th percentile charges already included the cost-to-charge adjustment. We reviewed the documentation of HCFA's computations and could not identify any point where the cost-to-charge ratio was used, nor could HCFA personnel show us where a cost-to-charge adjustment was used. Also, our analysis of HCFA's methodology shows that the adjustment was not made.

LIMITED DATA WAS AVAILABLE  
FOR SETTING PAYMENT RATES

HCFA acknowledged the weaknesses in the data used to set the ASC payment rates when it published the proposed rates. Specifically, HCFA said that the data had not been weighted to reflect frequency of use and that, for some procedures, the

available data included only one or two charges. HCFA also acknowledged that the data lacked randomness and that HCFA lacked control over the sample size and did not use a standard format or definition of terms in gathering the data.

As of January 1984, 150 ASCs had been certified to participate in the program. In the preamble to the proposed rule on ASC reimbursement, HCFA said it would develop a form to be used to collect cost and charge information from ASCs and that a random sample of ASCs participating in the program would be required to complete this form when HCFA re-evaluated the payment system or updated the rates. The final regulations require ASCs to provide HCFA on request with cost and charge data. As of July 1984, HCFA staff were working on a method for collecting current data from ASCs. We believe the certified ASCs are a source of more complete data and that HCFA should obtain and use new data to recompute payment rates.

#### PERFORMING SURGERY IN AMBULATORY SETTINGS MAY SAVE MONEY

We computed the costs to the Medicare program for five surgical procedures in five hospitals in Florida and compared them with the Medicare costs of those procedures in ASCs located near the hospitals. We chose procedures that would fall under specific diagnosis related groups (DRGs) which are the basis for Medicare's payment to hospitals for inpatient stays. Generally, the cost to Medicare would be lower for surgery performed in the ASC; however, cataract removal with lens implantation could be less expensive on an inpatient basis at two of the five hospitals than in nearby ASCs.

Our comparison was made under assumptions which would minimize the savings if the procedures were performed in an ASC rather than on an inpatient basis. Thus, the estimated savings we computed are conservative. One of those assumptions was that the physician would accept assignment for performing the surgery in an ASC. Normally, for physician services, the beneficiary must pay the first \$75 each year (the annual deductible) and Medicare then pays 80 percent of reasonable charges. However, as an incentive to beneficiaries to seek less costly care and to physicians to accept assignment, Medicare pays 100 percent of the reasonable charge if the physician accepts assignment under the ambulatory surgical benefit. This waiver of the deductible and the beneficiary's coinsurance can represent a substantial amount. For example, for cataract removal in an ASC Medicare pays \$1,549 at one Florida location if the physician accepts assignment and \$1,179 if the physician does not accept assignment. We also assumed that when the surgery was performed in the inpatient setting the beneficiary had to pay the \$75 annual part B deductible and the part A inpatient deductible (\$304 in 1983), thereby minimizing Medicare's cost. The results of our analysis are summarized below:

Savings in the ambulatory vs inpatient setting, in  
dollars and as a percent of the inpatient cost,  
based on payment rates effective in October 1983

<u>Procedures</u>	<u>Location A</u>		<u>Location B</u>		<u>Location C</u>		<u>Location D</u>		<u>Location E</u>	
Cataract removal with lens implantation (DRG 39)	\$202	7.9%	\$ 59	2.6%	\$259	10.0%	\$-91	-4.3%	\$-37	-1.7%
Carpal tunnel release (DRG 6)	475	35.3	352	30.0	521	37.5	232	22.1	276	25.1
Inguinal hernia (DRG 162)	987	47.7	801	44.0	1053	49.4	625	38.1	689	40.3
Breast biopsy (DRG 262)	684	45.9	541	41.9	737	47.7	402	34.9	512	40.5
Knee arthroscopy (DRG 232)	991	41.7	805	38.4	1060	43.3	622	32.5	689	34.8

These data show that performing the selected procedures in an ASC would generally be less costly to the Medicare program than if the procedures were performed in a nearby hospital on an inpatient basis where the hospital would be paid under the prospective payment system. For cataract removal in locations D and E, the inpatient setting may be less expensive than the ASC, assuming that the physician accepted assignment for the surgery in the ASC.

For the procedures we reviewed in Florida, physicians generally did not accept assignment. This is shown in the table below:

ASSIGNED AND UNASSIGNED CLAIMS FOR  
FIVE SELECTED PROCEDURES IN FLORIDA  
June 1, 1983, to November 11, 1983

	<u>Procedures</u>				
	<u>Cataract removal with lens implant</u>	<u>Carpal tunnel release</u>	<u>Inguinal hernia</u>	<u>Breast biopsy</u>	<u>Knee arthroscopy</u>
Number of claims	2,976	145	23	137	55
Assigned	23%	26%	39%	22%	18%
Unassigned	77%	74%	61%	78%	82%

Based on our comparison of five procedures at five locations in Florida, we believe the ambulatory surgery benefit may save Medicare dollars; however, because of the additional work that would be required, we did not try to estimate an overall amount of savings.

### CONCLUSIONS

HCFA set standard overhead amounts for ambulatory surgery that appear to save Medicare program dollars. However, in computing the standard overhead amounts HCFA did not adjust charge data by the cost-to-charge ratio as intended. As a result, the standard overhead amounts are 10 percent higher than intended.

In establishing its payment methodology, HCFA relied on a limited amount of data. We believe that more complete and current data should now be obtained and the payment rates for ASCs recomputed.

### RECOMMENDATIONS

We recommend that you recompute the ASC payment rates to incorporate the cost-to-charge adjustment. Also, we recommend that you obtain more complete and current data on ASC costs and develop payment rates from it.

### OBJECTIVES, SCOPE, AND METHODOLOGY

Our objectives were to evaluate HCFA's methodology for establishing the standard overhead amounts to be paid to ASCs and to compare the cost to Medicare for surgery performed in ambulatory versus inpatient settings.

We performed our work at HCFA headquarters, Baltimore, Maryland; HCFA's Atlanta region; and the Medicare intermediary and carrier for Florida.

At HCFA headquarters, we reviewed the process HCFA used to collect and analyze data to establish the standard overhead amounts. This included reconstructing HCFA's computations from aggregate charge data and reconstructing HCFA's evaluation which supported the selection of the 60th percentile charge. We did not verify HCFA's computations for the classification system or the average charge for each covered procedure. We also discussed the computation process with the HCFA personnel who were involved in it. At HCFA's Atlanta regional office, we discussed the ASC program with officials responsible for it in that region.

In Florida, we visited the state's intermediary and carrier, Blue Cross and Blue Shield of Florida. We discussed the program with intermediary and carrier officials, examined their claims payment system, and obtained information on the number of claims paid for procedures on the ambulatory surgery list for the period June 1, 1983, to November 11, 1983.

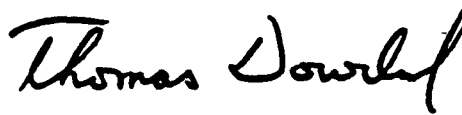
We obtained data on five hospitals' DRG payment rates and used the data collected to compare applicable part A and part B costs for inpatient surgical services to applicable part B costs for ambulatory surgery. For this comparison, we selected hospitals that were located near the ASCs. In comparing costs, we computed the hospitals' prospective payments for the inpatient surgical services and the overhead payments for an ASC in the hospitals' areas, including in both cases Medicare's share of the physicians' fees for performing the surgery.

Our work was performed in accordance with generally accepted government audit standards.

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We would appreciate hearing from you within 30 days on whatever action you take or plan concerning our recommendations.

Sincerely yours,



Thomas Dowdal  
Group Director