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Report to Congressional Requesters

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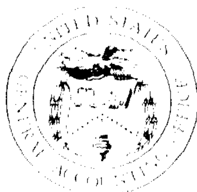
MEDICARE

Alternatives for Computing Payments for Hospital Outpatient Surgery



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Human Resources Division

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The Honorable John D. Rockefeller IV
Chairman, Subcommittee on Medicare
and Long Term Care
Committee on Finance
United States Senate

The Honorable Fortney H. (Pete) Stark
Chairman, Subcommittee on Health
Committee on Ways and Means
House of Representatives

On April 10, 1989, we testified before the Subcommittee on Health, House Committee on Ways and Means, on Medicare's reimbursement system for cataract surgery done in hospital outpatient departments.[1] We noted that with the current hospital payment system, the beneficiary's portion of the payment—or coinsurance—is based on hospital charges rather than on Medicare-allowable costs. This means that the beneficiary's share of the hospital payment for outpatient surgery is almost always greater than the 20-percent coinsurance for certain other Medicare-covered services, such as physician costs. Further, because charges for outpatient surgery differ across hospitals, coinsurance amounts can vary significantly, depending on where the surgery is performed.

Our subsequent analysis showed that the methodology for computing the blended payment amount (see p. 3) in the current payment system does not use beneficiary coinsurance amounts to reduce Medicare's portion of the hospital payment as much as it might. Thus, Medicare may be paying more than necessary for hospital outpatient surgery.

A Medicare prospective payment system for surgery performed in hospital outpatient departments is now being considered and, if adopted, should eliminate many of the shortcomings of the current system. Because it may be some time before a new system is implemented, however, an interim solution may be desirable. This report discusses three alternatives to the current payment methodology that the Congress should consider.

[1] Medicare: GAO Views on the Payment System for Outpatient Cataract Surgery (GAO/T-HRD-89-16, Apr. 10, 1989).

The first alternative proposes a mechanical change to the payment methodology that would reduce Medicare costs for hospital outpatient surgery. This alternative would not, however, address the inequities related to beneficiary coinsurance. The other two alternatives propose changing the basis for determining beneficiary liability for hospital outpatient surgery; these alternatives would reduce beneficiary coinsurance amounts at little or no cost to the Medicare program. All three alternatives reduce payments to hospitals.

Background

The Medicare program, authorized by title XVIII of the Social Security Act (42 U.S.C. 1395), helps pay medical costs for about 30 million people aged 65 years and older, as well as for about 3 million disabled people. Medicare is administered by the Health Care Financing Administration (HCFA), within the Department of Health and Human Services (HHS). Benefits are provided under two parts. Medicare part A covers inpatient hospital services, home health services, and other institution-based services. Part B covers physician services, outpatient hospital services, and various other health services, such as laboratory and diagnostic tests. In fiscal year 1990, Medicare is expected to spend about $95 billion.

Since implementation of Medicare's prospective payment system for inpatient hospital services in fiscal year 1984, there has been an increasing shift in medical services from the inpatient to the outpatient setting. As a result, it has been estimated that outpatient expenditures have increased about 19 percent a year since then to an estimated $7 billion in 1988. The shift from inpatient to outpatient services has been especially noticeable for surgery, which accounts for about 25 percent of all outpatient expenditures.

The Medicare payment for outpatient surgery under part B generally has two components—(1) a physician payment made to the surgeon and anesthesiologist and (2) a facility payment made to either a hospital outpatient department or an ambulatory surgery center (ASC). The facility payment represents reimbursement for use of an operating room, nursing services, drugs, surgical dressings and supplies, and other services or items directly related to the surgical procedure.

As with most Medicare-covered services, beneficiaries share in the cost of outpatient surgery. After meeting the part B annual deductible of $75, the beneficiary pays 20 percent of the Medicare-approved charges

for physician services related to outpatient surgery; Medicare pays 80 percent.[2]

The same proportional cost-sharing arrangement applies to the facility payment when surgery is performed in an ASC. Currently, Medicare pays ASCs a predetermined amount that varies depending on the type of procedure performed.[3] Medicare and the beneficiary share in the payment on an 80-20 basis.

This is not the case, however, with the Medicare facility payment to hospitals for surgery performed in their outpatient departments. The beneficiary coinsurance, calculated and billed by the hospital, is based on 20 percent of the hospital's submitted charges for a surgical procedure, whereas Medicare usually pays based on a blend of the hospital's costs and the amount paid to ASCs for the same surgical procedure.[4]

An example of the current methodology used to determine the Medicare and beneficiary share of the facility payment for hospital outpatient surgery is shown in table 1. The computations are based on the following hypothetical data:

- A surgical procedure (cataract surgery) was performed in a hospital outpatient department, and the total facility charge billed to the Medicare program was $2,000.
- The beneficiary coinsurance was $400 (20 percent of the $2,000 facility charge).
- The hospital's ratio of cost-to-charges was 70 percent.[5]

[2]When physicians agree to accept the Medicare determination of reasonable charges as payment in full (assigned claims), the beneficiary is responsible for paying 20 percent of the reasonable charge. When the physician does not agree (unassigned claims), the beneficiary is also responsible for the difference between Medicare's reasonable charge and the physician's charge.

[3]All covered ASC surgical procedures at the time of our review were classified into four payment groups. Medicare pays a prospectively determined amount for each group on the basis of the national average cost of the procedures in a specific group.

[4]The Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509) provides that hospitals be paid the lesser of (1) their reasonable costs or customary charges or (2) a blend of the hospital costs and the rate paid to ASCs. Effective for hospital cost-reporting periods, beginning on or after October 1, 1988, the blend is 50 percent of the hospital's costs and 50 percent of the ASC rate.

[5]Hospital charges for outpatient surgery are converted to estimated Medicare-allowable costs using a ratio of cost-to-charges developed from the hospital's Medicare cost report for the previous year. Payments based on these Medicare-allowable costs, less beneficiary coinsurance, are made on an interim basis throughout the year until the final cost settlement is made.

- The Medicare facility payment to ASCs for cataract surgery was $600; after the 20-percent beneficiary coinsurance amount was deducted, the Medicare ASC payment amount was $480.

Table 1: Computation of Medicare Payment and Beneficiary Coinsurance Amount for Hospital Outpatient Surgery

		Current law
Billed charges	$2,000	
Ratio of cost-to-charges	x .7	
Medicare-allowable costs	$1,400	
Less beneficiary coinsurance	- 400	
Preblend amount	$1,000	
Blend factor	x .5	$500
ASC payment amount	$480	
Blend factor	x .5	+ 240
Medicare facility payment		$740
Beneficiary payment		+ 400
Total payment to hospital		**$1,140**

As shown in table 1, the billed charges are converted to estimated Medicare-allowable costs by using the hospital's ratio of cost-to-charges. The Medicare-allowable costs are then reduced by the beneficiary coinsurance, and the resulting hospital cost is blended with the ASC payment amount to arrive at the final Medicare facility payment. Medicare's payment ($740) plus the beneficiary coinsurance amount ($400) make up the total payment received by the hospital. In this hypothetical case, the beneficiary coinsurance of $400 represents 35 percent of the total hospital payment of $1,140.

Medicare's two payment systems—a prospective payment system for surgery performed in ASCs and a cost-based system for hospital outpatient departments—result in large reimbursement differences for similar procedures in the two settings. In the Omnibus Budget Reconciliation Act of 1986, the Congress mandated that HHS (1) develop a proposal for a prospective payment system for hospital outpatient surgery and (2) submit a final report to the Congress by April 1, 1989. This was an attempt to provide a more uniform Medicare payment system and to help reduce outpatient surgical costs. HHS had not issued this report as of February 1, 1990.

Shortcomings in the Current Payment Methodology

Based on our analysis of Medicare's current hospital payment system, we believe that there are two problems associated with the computation and application of beneficiary coinsurance amounts. First, because of a quirk in the current method used to compute the blended payment amount, the Medicare program may be paying more than necessary for surgery performed in hospital outpatient departments. Second, determining the beneficiary coinsurance using billed charges rather than Medicare-allowable costs means that the beneficiary's portion of the hospital payment is usually higher than the 20-percent share applicable to certain other Medicare services. As mentioned earlier, we developed three alternative computation methods to address these shortcomings.

Medicare Not Benefiting Fully Under Current Law

Medicare's current method of computing the blended payment amount for hospital outpatient surgery does not take full advantage of beneficiary coinsurance amounts in order to reduce Medicare's payments as much as possible. Under current law, the beneficiary coinsurance amount is subtracted before computing the blended amount. If the coinsurance was deducted after computing the blended amount, Medicare payments would be lower. Table 2 helps illustrate how the timing of the application of the beneficiary coinsurance in the blend process can affect the Medicare payment.

Table 2: Reduction in Medicare Facility Payment When Beneficiary Coinsurance Is Deducted After Computing the Blend
(Alternative 1)

	Current law		Alternative 1	
Billed charges	$2,000		$2,000	
Ratio of cost-to-charges	x .7		x .7	
Medicare-allowable costs	$1,400		$1,400	
Less beneficiary coinsurance	- 400			
Preblend amount	$1,000		$1,400	
Blend factor	x .5	$500	x .5	$700
ASC payment amount	$480		$600	
Blend factor	x .5	+ 240	x .5	+ 300
Medicare blended amount				$1,000
Less beneficiary coinsurance				- 400
Medicare facility payment		$740		$600
Beneficiary payment		+ 400		+ 400
Total payment to hospital		**$1,140**		**$1,000**

In alternative 1, the billed charges are converted to Medicare-allowable costs by using the hospital's cost-to-charge ratio. These costs are combined with the ASC payment amount to produce a blended amount. Beneficiary coinsurance, representing 20 percent of billed charges (.20 x $2,000), is subtracted from the blended amount to arrive at Medicare's facility payment to the hospital. As shown in table 2, the Medicare facility payment is reduced by $140, from $740 to $600, by deducting the beneficiary coinsurance after the blended amount is computed.[6]

We brought this shortcoming to the attention of HCFA officials and discussed our proposed alternative for correcting it. HCFA officials supported this alternative because it would reduce Medicare program payments and would be no more difficult to administer than the current payment system. HCFA officials developed a proposal based on this alternative for inclusion in their fiscal year 1992 legislative package.

Beneficiary Coinsurance Amounts for Hospital Outpatient Surgery Can Be Lowered

Under current law, beneficiary coinsurance for surgical procedures performed in hospital outpatient departments is equal to 20 percent of the billed facility charge. As discussed in our April testimony, there are a number of problems with the practice of basing beneficiary coinsurance on billed charges. For outpatient surgery, hospital charges are almost always higher than the Medicare-allowable costs that form the basis of the Medicare portion of the facility payment. Thus, as illustrated earlier in table 1, the beneficiary's share of the payment is usually going to be more than 20 percent of the total payment amount. Further, billed charges generally differ more than costs among hospitals and hospital facility charges are generally much higher than ASC payment amounts. Thus, using charges as a base means that beneficiary coinsurance amounts for the same procedure can vary by hundreds of dollars, depending on where the surgery is performed.

One approach to reducing these inequities—alternative 2—would be to base beneficiary coinsurance on Medicare-allowable costs rather than on hospital-submitted charges. Table 3 illustrates this alternative and its potential for reducing both beneficiary coinsurance and Medicare's facility payments.

[6]Under current law, the blend is applied to the net Medicare-allowable costs ($1,000) and the net ASC payment amount ($480)—that is, after deducting the beneficiary coinsurance from both. With alternative 1, the blend is applied to the gross Medicare-allowable costs ($1,400) and, for consistency, we believe it should also be applied to the gross ASC payment amount ($600). Using the net ASC payment amount in alternative 1 would lower the Medicare payment and the total hospital payment even further.

Table 3: Computing Beneficiary Coinsurance Based on Medicare-Allowable Costs (Alternative 2)

		Current law		Alternative 2
Billed charges	$2,000		$2,000	
Ratio of cost-to-charges	x .7		x .7	
Medicare-allowable costs	$1,400		$1,400	
Less beneficiary coinsurance	- 400			
Preblend amount	$1,000		$1,400	
Blend factor	x .5	$500	x .5	$700
ASC payment amount	$480		$600	
Blend factor	x .5	+ 240	x .5	+ 300
Medicare blended amount				$1,000
Less beneficiary coinsurance				- 280
Medicare facility payment		$740		$720
Beneficiary payment		+ 400		+ 280
Total payment to hospital		**$1,140**		**$1,000**

In alternative 2, the billed charges are converted to Medicare-allowable costs by using the hospital's cost-to-charge ratio. These costs are combined with the ASC payment amount to produce a blended amount. To arrive at Medicare's facility payment to the hospital, the beneficiary coinsurance is computed by taking 20 percent of the Medicare-allowable costs (.20 x $1,400) and subtracting the coinsurance from the blended amount.

As shown in table 3, this alternative reduces the beneficiary coinsurance amount in absolute terms—from $400 to $280—and as a percentage of the total hospital payment—from 35 to 28 percent. The reduction in the Medicare payment—from $740 to $720—is due, in part, to (1) this alternative and (2) the change in the timing of the application of the beneficiary coinsurance in the blend amount (as discussed in alternative 1 on pp. 5-6).

HCFA officials said that implementing this alternative would require some adjustment to the claims-processing system, but the computation should be no more difficult to make than that under current law. For ASC-covered services, the beneficiary coinsurance would continue to be determined by the hospital. Using alternative 2, however, would require hospitals to take one additional step in order to compute the correct coinsurance amount. A hospital would now have to apply its Medicare ratio of cost-to-charges from the previous cost-reporting period to its

billed charges to arrive at the coinsurance amount. The computation of the final Medicare facility payment would continue to be done by the intermediary.

With this alternative, some hospitals would be underpaid if the actual ratio of cost-to-charges was higher than the estimated ratio used during the cost-reporting period. The ratio of cost-to-charges used in the current payment system is an estimate based on the hospital's Medicare cost report for the previous year (see p. 3). The intermediary determines the actual ratio at final cost settlement for the period. The coinsurance amount is currently unaffected by a change in the cost-to-charge ratio because it is based on charges rather than on allowable costs. Coinsurance amounts based on Medicare-allowable costs, however, would be affected by such a change. These amounts could be understated or overstated if the estimated ratio used during the period is different from the final ratio. If the estimated ratio is lower, hospitals would be underpaid and would have to absorb any payment shortfalls because it would not be politically or administratively feasible to bill beneficiaries at the end of the period.

Another approach to lowering beneficiary coinsurance payments for hospital outpatient surgery—alternative 3—would be to make the beneficiary coinsurance exactly 20 percent of the Medicare blended amount. This alternative is compared with the current payment method in table 4.

Table 4: Computing Beneficiary Coinsurance Based on the Medicare Blended Amount (Alternative 3)

	Current law		Alternative 3	
Billed charges	$2,000		$2,000	
Ratio of cost-to-charges	x .7		x .7	
Medicare-allowable costs	$1,400		$1,400	
Less beneficiary coinsurance	- 400			
Preblend amount	$1,000		$1,400	
Blend factor	x .5	$500	x .5	$700
ASC payment amount	$480		$600	
Blend factor	x .5	+ 240	x .5	+ 300
Medicare blended amount				$1,000
Less beneficiary coinsurance				- 200
Medicare facility payment		$740		$800
Beneficiary payment		+ 400		+ 200
Total payment to hospital		**$1,140**		**$1,000**

In alternative 3, the billed charges are converted to Medicare-allowable costs by using the hospital's cost-to-charge ratio. These costs are combined with the ASC payment amount to produce a blended amount. To arrive at Medicare's facility payment to the hospital, the beneficiary coinsurance is computed by taking 20 percent of the blended amount (.20 x $1,000) and subtracting the coinsurance from the blended amount.

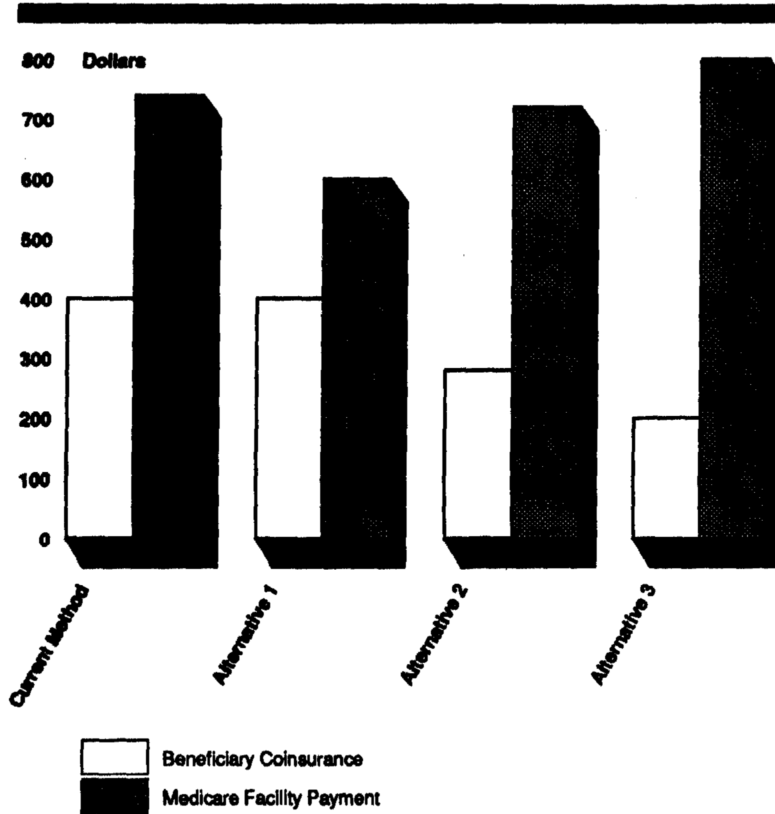
Of the three alternatives, this one would result in the greatest reduction in beneficiary liability. It also would result in the cost of hospital outpatient surgery being shared by Medicare and the beneficiary on an 80-20 basis. The reduction in beneficiary coinsurance, however, would increase Medicare facility payments (from $740 to $800 in our example).

Further, HCFA officials believe that alternative 3 would be very difficult to administer. In addition to the requirements discussed for alternative 2, they said, hospitals would have to know the Medicare payment rates for the approximately 1,500 approved ASC outpatient surgery procedure codes, calculate the blend, and then compute the coinsurance amount. Hospitals would have to do this for each outpatient surgery bill. In contrast, under current law, intermediaries aggregate all outpatient surgery Medicare-allowable costs to compute the blended amount at final cost settlement.

Summary

The three proposed alternatives for paying hospitals for surgery done in their outpatient departments would have varying effects on Medicare and beneficiary payments relative to the current payment methodology. Figure 1 illustrates this by comparing (1) beneficiary coinsurance amounts, (2) Medicare facility payments, and (3) total hospital payments under the current payment methodology and under the alternatives discussed.

Figure 1: Comparison of Current and Alternative Payment Methodologies for Hospital Outpatient Surgery



Note: The total hospital outpatient surgery payment under the current payment system is $1,140. With each of the alternatives, the total hospital payment is $1,000.

As shown in figure 1, the total hospital payment would be lowered from $1,140 with the current payment methodology to $1,000 with each of the three alternatives. With alternative 1, which would make a mechanical change to the blend methodology, the entire reduction in hospital payments would be used to lower the Medicare payment. As such, there would be no relief to the beneficiary—the coinsurance amount with this

alternative is the same as with the current system. Beneficiary coinsurance, as a percentage of the total hospital payment, is highest with this alternative.

Alternative 2, which bases beneficiary coinsurance on Medicare-allowed costs rather than on hospital-submitted charges, splits the reduction in the hospital payment between the Medicare program and the beneficiary. The beneficiary coinsurance amount, as a percentage of the total hospital payment, is lower than under the current payment system but is still greater than 20 percent.

Alternative 3, which would make the beneficiary coinsurance amount exactly 20 percent of the Medicare blended payment amount, uses the entire reduction in the hospital payment to lower the beneficiary coinsurance amount. Accordingly, the Medicare payment is highest with this alternative. Further, although this alternative provides the most equitable treatment for the beneficiary, it may not be administratively feasible to implement. Thus, for the Medicare program and beneficiaries to share in the payment for hospital outpatient surgery on an 80-20 basis would probably require the implementation of a prospective payment system.

Matter for Congressional Consideration

Because it may be some time before a prospective payment system for hospital outpatient surgery is designed and implemented, we believe the Congress should consider an interim solution to the shortcomings of the current payment methodology. Depending on the policy objectives to be satisfied, we believe that either alternative 1 or 2 is suitable.

At the Subcommittees' request, we developed and assessed alternative reimbursement methods for hospital outpatient surgeries. We discussed these alternatives with HCFA officials and also reviewed a copy of HCFA's legislative proposal, which was developed based on our meetings.

We carried out this review between June and October 1989 in accordance with generally accepted government auditing standards.

We are sending copies of this report to the Director of the Office of Management and Budget, the Secretary of HHS, the Administrator of HCFA, and other interested parties on request.

If you or your staff have any questions concerning this report, please call me on (202) 275-5451. Other major contributors are listed in appendix I.

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