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MEDICARE:
GAO Views On The Payment System
For Outpatient Cataract Surgery

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Before the
Subcommittee on Health
U.S. House of Representatives
Committee on Ways and Means

SUMMARY

The Congress and the Department of Health and Human Services are studying changes to Medicare's system of reimbursing hospitals for outpatient surgery. GAO's review of cataract surgery, the most frequently performed outpatient surgery, illustrates the need to revise the current cost-based payment system for hospitals.

This system has a number of problems. First, there is a lack of assurance that the payments made to hospitals reflect the actual cost of providing efficient services. For example, the cost reimbursement system is vulnerable to hospitals shifting inpatient costs to outpatient departments.

Second, the current payment system treats beneficiaries inequitably in determining their share of the payment for outpatient services. In fact, beneficiaries who have cataract surgery in an outpatient hospital department may pay over 200 percent more than beneficiaries who have the same surgery at Ambulatory Surgical Centers.

Third, the current payment system fails to provide adequate incentives to control Medicare costs. GAO found that reimbursement policies for surgically implanted intraocular lenses do not promote cost conscious procurement practices. As a result, Medicare and beneficiary payments for similar lenses vary significantly.

GAO also found a need to improve Medicare safeguards to help assure that outpatient cataract surgery is medically necessary. GAO's review of a sample of medical records in four states revealed that the information needed to assure that the surgery was necessary was missing in about one-third of the cases.

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss our review of Medicare payments for cataract surgery, one of the most frequently performed procedures done on an outpatient basis. Overall, our work supports revising the current Medicare reimbursement system for outpatient hospital surgery.

Medicare payments for cataract surgery are significantly higher on average for hospital outpatient departments than for Ambulatory Surgical Centers (ASCs). We believe that some of this payment differential reflects legitimate cost differences between the two settings. However, the current cost-based payment system for hospitals provides both the incentive and the opportunity to make costs in the outpatient department appear higher than they are. Thus, not all of the higher payments to hospitals may be justified.

We also noted that under the current hospital payment system, the beneficiary's portion of the payment, or coinsurance, is based on charges rather than on Medicare-computed costs. As a result, beneficiary coinsurance amounts can vary significantly and their share of the Medicare-allowed cost of the surgery is almost always greater than the intended 20 percent.

In addition to reimbursement issues, we looked at a sample of cataract surgeries in four states to evaluate the adequacy of the documentation supporting the need for the surgery. We also reviewed the timing of cataract surgery done on the second eye in those states. Based on our analyses, we question whether Medicare had reasonable assurance that all of these cataract surgeries were medically necessary.

BACKGROUND

Since the implementation of a Medicare prospective payment system (PPS) for hospitals in fiscal year 1984, we have witnessed an increasing shift in medical services from the inpatient to the outpatient setting. This is illustrated by the fact that hospital revenues from outpatient services grew at an average annual rate of 16.7 percent from 1983 to 1987, about three times faster than inpatient hospital revenues grew during the same period.

The shift to the outpatient setting has been especially noticeable for surgery. About 40 percent of all hospital surgeries are now performed on an outpatient basis compared to about 20 percent in 1983. At the same time, the number of free-standing ASCs has increased about ten-fold from 87 in 1983 to 838 today.

One of the most frequently performed surgical procedures in the outpatient setting is the removal of a cataract with the insertion of a prosthetic lens--cataract surgery. In 1987, Medicare paid for about 1 million outpatient cataract surgeries.

Cataract surgery is a standardized, low-risk procedure and the choice of setting appears to be based primarily on where the ophthalmologist practices. While a small number of outpatient cataract surgeries are done in physician offices, most are performed either in a hospital outpatient department or an ASC. The Medicare payment for cataract surgeries done in hospital outpatient departments and ASCs generally has three components--a payment made to the surgeon; a facility payment that primarily represents reimbursement for the operating room, pharmacy items, and surgical supplies; and a separate payment for the intraocular lens (IOL) that is implanted during the surgery.

My statement today will present our concerns about Medicare facility payments and payments for IOLs.

MEDICARE FACILITY PAYMENTS DIFFER BY SURGICAL SETTING

Medicare uses two different methods to pay for facility costs related to cataract surgery--a prospective payment system for ASCs and a system based on reasonable costs for hospital

outpatient departments. The two methods result in large differences in payments between the two settings, and not all of the payment differences may be justified. A prospective payment system for hospital outpatient surgery has been mandated by the Omnibus Budget Reconciliation Act of 1986. When implemented, this system should eliminate the negative incentives inherent in a cost-based system and provide a more uniform Medicare payment system for outpatient surgery.

Medicare has established payment groupings for surgical procedures performed at ASCs, and pays the ASC a prospectively-determined amount for each group based on the national average cost of the procedures in it. For cataract surgery, which is included in the highest payment grouping, the Medicare payment rate was $599 (unadjusted for wages) for the period ending June 1988. The actual payment from Medicare would be about $479, the amount remaining after subtracting the 20 percent coinsurance amount that is the responsibility of the beneficiary.

Until October 1987, the Medicare payment for the facility component of surgery done in hospital outpatient departments was based entirely on a reasonable cost reimbursement method. The Omnibus Budget Reconciliation Act of 1986 modified this payment method, and hospitals are now paid the lesser of their reasonable costs or 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 hospital costs and 50 percent of the ASC rate.

Facility costs for hospital outpatient cataract surgery--and Medicare payments based on these costs--are generally higher than those for ASCs. During the period October 1987 to June 1988, the mean facility costs for hospital outpatient departments was $1,104, almost double the $599 facility cost for ASCs.

Some of the facility cost difference between hospitals and ASCs are due to the fact that hospital outpatient department costs reflect more than just the direct costs of this department. The facility costs also include a portion of the hospital's overall general and administrative costs, such as maintenance and the cost of the personnel office. Therefore, it can be expected that facility costs of hospital outpatient departments would be higher than ASC costs because of legitimate differences in overhead and operating expenses.[1]

However, there is always the danger that hospitals can increase revenues by inappropriately allocating more of their costs from inpatient services, which are paid prospectively, to the outpatient department where they are still paid on a cost-

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[1]For example, maintenance expenses for a large 600-bed hospital would be expected to be higher than those for an ASC. Other factors, such as maintaining standby capacity for emergency medical services and a round-the-clock schedule, also help explain higher hospital costs.

basis. Such questionable cost shifting can occur through the complex cost allocation system without being easily detected.

Because of the limited time available and complexity of the hospital cost allocation process, we did not attempt to determine the extent to which hospitals may have shifted costs to the outpatient department. However, we were told by an official at one hospital we visited that the hospital had adopted a pricing policy to maximize hospital revenues by selectively raising outpatient charges, thereby shifting costs to the outpatient department. He said this was done to offset anticipated losses from inpatient services.

Higher costs for hospital outpatient departments may also be due to other factors, such as operating inefficiencies and billing and coding inconsistencies. Research sponsored by the Health Care Financing Administration (HCFA) is attempting to determine the factors that explain the relative cost differences between ASCs and hospital outpatient departments.

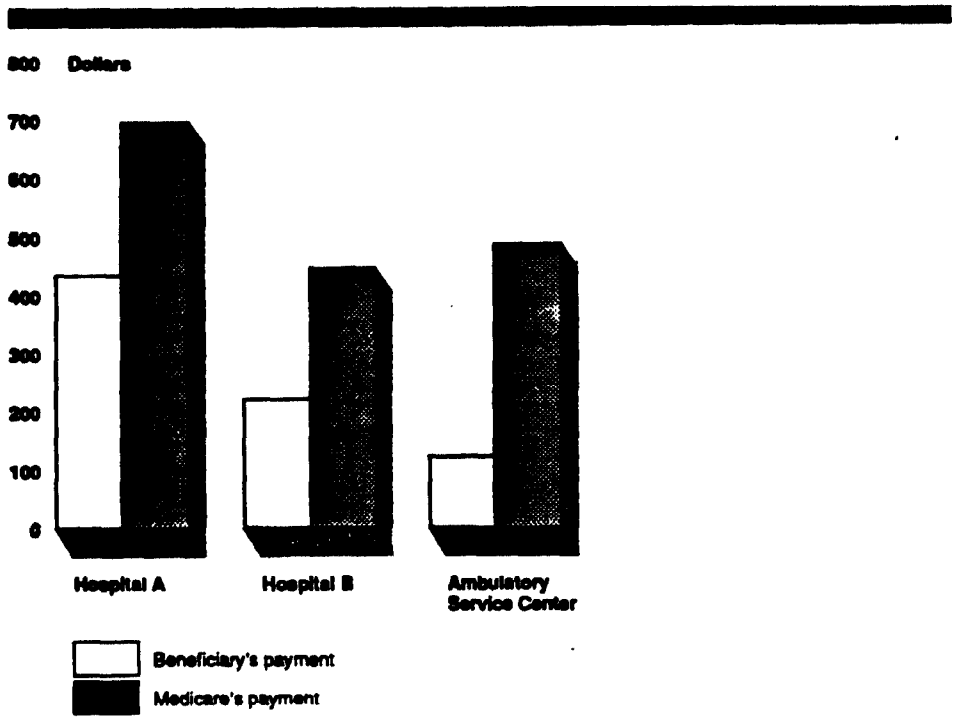
In summary, we support the concept of a prospective payment system for hospital outpatient facility costs because the current cost-based system does not offer adequate assurance that the higher payments to hospitals are based on the costs of efficient delivery of services.

BENEFICIARY LIABILITY VARIES GREATLY ACROSS SURGICAL SETTINGS

Another problem with the current Medicare payment system for hospital facility costs relates to how the beneficiary's share of these costs, or coinsurance, is computed. For outpatient surgery, the 20 percent coinsurance for the facility payment is computed on hospital billed charges rather than on the Medicare-allowed cost. The Medicare payment is computed by subtracting the beneficiary's payment from the allowable costs. Since charges are almost always higher than costs, 20 percent of charges usually represents more than 20 percent of allowable costs, and the Medicare program almost always ends up paying less than 80 percent of allowed costs.

Charges for cataract surgery differ across hospitals, and thus beneficiary coinsurance amounts can vary by several hundred dollars depending on where the cataract surgery is performed. Figure 1 illustrates the difference in the beneficiary liability for cataract surgery done at two hospitals and at an ASC.

Figure 1: Differences in Medicare and Beneficiary Payments for Cataract Surgery



As can be seen, the coinsurance amount of $434 for the beneficiary treated in Hospital A--a hospital with facility costs and charges close to the national average--was almost twice that of the beneficiary treated in Hospital B, a hospital with relatively low facility costs. In addition, even though the facility cost at Hospital B was less than that for the ASC, the beneficiary's coinsurance amount at Hospital B was almost twice that of the beneficiary treated at the ASC.

Another effect of using billed charges to determine the beneficiary coinsurance amount is that beneficiaries pay more than 20 percent of the Medicare-computed cost of the surgery. Average billed charges for cataract surgery are almost twice the average facility cost upon which the Medicare share of the payment is based. For example, the coinsurance amount of $434 for the beneficiary treated in Hospital A represents about 38 percent of the Medicare allowed cost.

Another factor that affects beneficiary liability is the computation of the Medicare blended payment. As we mentioned earlier the Medicare payments made to outpatient hospital departments are currently subjected to a blend of their costs and the ASC payment rate. In computing the blended payment, however, the beneficiary does not share with Medicare the benefit of any resulting payment reductions. Therefore, a hospital can increase its revenue by increasing its charges relative to its costs. This will increase the beneficiary's liability by more than the payment from the Medicare program is reduced.

Because of these inequities, we believe that the method used to compute beneficiary coinsurance should be considered carefully when designing a prospective payment system for hospital outpatient surgery. Indeed, because it may be sometime before a prospective system is implemented, Congress may want to reexamine the current method of computing beneficiary coinsurance

amounts immediately. We would be happy to discuss alternative approaches for dealing with this problem with the Committee.

THE CHALLENGE OF SETTING EQUITABLE PAYMENT RATES FOR IOLs

To this point, we have been discussing our concerns about Medicare and beneficiary payments for facility costs associated with cataract surgery. We have similar concerns about Medicare payments for the IOL that is implanted during the surgery.

Medicare payments for IOLs are separate from the facility payment for both ASCs and hospitals. ASCs are paid by Medicare carriers based on the reasonable charge concept used for determining payments for physician services. Hospital payments for IOLs are determined using the reasonable cost method described earlier, but without subjecting the resulting cost to the blending process. Based on a requirement in the Omnibus Budget Reconciliation Act of 1987, HHS has proposed paying ASCs a flat rate of $200 for IOLs and paying hospitals a blend of the ASC rate and the hospital's acquisition cost for the IOL.

There have been, and probably will continue to be, differing views on whether the amount proposed by HHS is reasonable. Private studies suggest that the rate for IOLs should be closer to $250, while a study done by the HHS Inspector General

concludes that $200 may be a reasonable acquisition price for most facilities. The fact that a Canadian hospital that we visited can negotiate an $80 lens price with an American manufacturer suggests that even $200 may be generous.

The scope of our efforts to address this issue was more limited than that of previous studies, and thus we cannot draw any firm conclusions about the amount that should be paid for IOLs. However, our observations suggest that current acquisition costs for IOLs are not always a reflection of prudent buying practices.

As part of our work, we gathered information on IOL acquisition costs at seven hospitals and eight ASCs in four states--Arizona, Florida, North Carolina, and Washington. Consistent with the findings from more comprehensive studies, we observed wide variation in the acquisition cost of IOLs across the facilities visited. For example, costs for one brand of IOL ranged from $94 to $310; across all brands, costs ranged from $90 to $450.

Average acquisition cost at the 15 facilities visited ranged from $98 to $373.[2] The information obtained at these

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[2]This was the average cost from the invoices provided by each facility, not weighted by purchase or usage volume.

facilities suggests that there is some relationship between acquisition cost and volume. For example, the facility with the lowest average cost was a Washington hospital that did over 1,100 cataract surgeries during the period covered by our review. This hospital was able to seek bids and negotiate a volume-guaranteed contract.

It appears, however, that there is a stronger relationship between acquisition costs and Medicare IOL reimbursement policies. This is especially true for ASCs, where payment policies affecting them are established by Medicare carriers and can vary significantly. For example, in both Florida and Arizona, the Medicare carriers' allowed amount for IOLs for the ASCs we visited was about $350.[3] Because the ASCs in these two states could keep the difference between this amount and their acquisition costs, they had an incentive to obtain favorable IOL prices but yet charge Medicare and beneficiaries the full amount allowed. Three of the four ASCs we visited had average acquisition costs under $200; the fourth had an average acquisition cost of about $240--still profitable under this payment arrangement.

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[3]In both states, Medicare pays the lesser of reasonable charges or the Medicare allowed amount of about $350. However, the reasonable charge for all four ASCs visited in those states exceeded $350, and thus ASCs were paid at the allowed amount.

In contrast, the Medicare carrier for the state of Washington currently pays ASCs their acquisition cost of IOLs up to $203. Not surprisingly, the two Washington ASCs visited had acquisition costs of $198 and $202. Officials at one of these ASCs, a high-volume facility, told us that they probably could obtain IOLs for less, but had no incentive to do so.

The Medicare carrier in North Carolina also reimbursed for IOLs based entirely on acquisition price, with no provision for profit. Thus, this payment policy provided little incentive to negotiate for low prices when purchasing IOLs. One of the high-volume ASCs visited in North Carolina was paying $368 for a lens that lower volume providers in the other states were buying for an average of $207. This ASC also paid $390 for a second lens model. The Canadian hospital mentioned earlier purchased the same model lens from the same manufacturer for $80.

In summary, it appears that a prospective rate for IOLs--if set correctly--could provide facilities with more incentive to negotiate for lower IOL prices, thus reducing Medicare and beneficiary payments from their current levels. However, along with setting a prospective rate, we believe that HCFA should begin collecting data on IOL acquisition costs and procurement practices because future savings to Medicare may be possible.

NEED FOR SURGERY WAS NOT ALWAYS ASSURED

While reimbursement reform should improve the equity and reasonableness of Medicare payments, payment reform will not necessarily control volume. Accordingly, it is important that utilization safeguards, including adequate documentation, are used to assure that outpatient surgery is necessary. To get an indication of the effectiveness of existing safeguards, we reviewed documentation in a sample of patient medical files, and analyzed physician practice patterns concerning the timing of cataract surgery performed on the second eye. This work was done in Arizona, Florida, North Carolina, and Washington.

According to the American Academy of Ophthalmologists, elective cataract surgery is considered necessary when the patient's lifestyle and daily functions are impaired due to loss of visual acuity caused by the cataract. As with any elective surgery, it is important to document the need for cataract surgery in order to help protect patients from undue risk and payers from unnecessary expenses.

To determine if the need for cataract surgeries performed on Medicare beneficiaries was being properly documented, we reviewed medical records and patient histories from a random sample of 200 cataract surgeries performed in 1987--50 from each of the four states. Our Chief Medical Advisor and a practicing

ophthalmologist consultant agreed that documentation was inadequate in 77 of the 200 cases. Consequently, we estimate that ophthalmologists failed to adequately document the need for cataract surgery in about 29 to 45 percent of the surgeries performed in the four states in 1987.

We recognize that inadequate documentation by itself does not prove conclusively that cataract surgery is unnecessary. However, it raises questions about the utilization safeguards used in the Medicare program. Our analysis of the timing of second eye surgeries raises similar questions.

Often Medicare patients have cataracts in both eyes, with one eye being significantly worse than the other. Following cataract surgery on the more severely impaired eye, many patients do not seek a second operation. When a second operation is needed, the American Academy of Ophthalmologists states that, "it is preferable for surgery on the second eye to be delayed until the first eye has completely healed and a final refraction has been performed. This is usually at about 3 months after [the first] surgery." This period allows an evaluation of the effect of the first surgery on the patient's lifestyle.

To determine how quickly ophthalmologists perform cataract surgery on the second eye, we analyzed data on all cataract surgeries performed in the four states in 1987. We found that

about 27 to 38 percent of the second eye surgeries were done within 6 weeks of the first cataract surgery.

In summary, our review of medical files and physician practice patterns in the four states suggests that improved safeguards are needed in those states to protect both the program and patients from the costs and risks of unnecessary surgery. In an effort to improve safeguards, HCFA has contracted with Peer Review Organizations to preapprove outpatient cataract surgeries. However, the effectiveness of this move is unknown because the preapproval process has just begun.

This concludes my prepared statement. I would be happy to answer any questions that you may have at this time.