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Repricing Specialty Hospital Outpatient Services Using ASC Prices

Final Report

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SECTION 1 INTRODUCTION

1.1 Policy Issues

Some critics of physician-owned specialty hospitals (SPHs) claim that Medicare's payment system provides financial incentives for physicians either (a) to convert their Ambulatory Surgical Center (ASC) in which they have an ownership share into an inpatient orthopedic or surgical specialty hospital, or (b) to invest directly in a new specialty hospital. In particular,

One alleged financial incentive in favor of physicians investing in a specialty hospital compared with an ASC is the higher average facility payment under the Outpatient Prospective Payment System (OPPS) for hospitals compared with the ASC facility fee schedule.¹

Whether outpatient rates are actually higher in specialty hospitals is an empirical question. In fact, Winter (2003) showed that the highest volume ASC services received higher Medicare payments under the ASC fee schedule than under the OPPS. However, because some ASC-eligible services are paid more under the OPPS system, it is possible that payments are higher in specialty hospitals depending upon their mix of services.

A second financial incentive in favor of organizing a specialty hospital is Medicare payments for outpatient services that are prohibited by the Stark "self-referral" Laws in physician-owned ASCs. Of particular concern would be highly profitable lab and radiology services.

The Stark Laws prohibit physicians in ASCs from referring patients for ancillary services to any facility in which they have an ownership share. Physicians owning part of a hospital, by contrast, are not limited in their referral patterns and can refer patients to their specialty hospitals for MRIs, CT scans, and other potentially profitable services.

CMS contracted with RTI to determine the potential revenue gain from OPPS-ASC pricing differentials and prohibited self-referral services. We compared the magnitude of these two gains to the inpatient revenues in specialty hospitals versus ASCs to assess their importance in the potential decision to open or convert a facility to a specialty hospital.²

1.2 Methods and Data

To quantify gains, we repriced specialty hospital outpatient claims using ASC payment algorithms. We determined how much the specialty hospital would have been paid for its

¹ The physician's Part B payment for procedures is usually identical in either location. It is only the Part A facility payment that might be different.

² For a detailed analysis of the financial incentives from inpatient services, see Cromwell, et al., 2005, Greenwald, et al., 2006, and MedPAC 2005.

outpatient care if the services had been classified and reimbursed as an ASC. In our analysis, we only repriced specialty hospital outpatient claims. We did not analyze any ASC claims to determine differences in procedure mix. Medicare payment incentives favoring orthopedic or surgical specialty hospitals are the primary focus of this report given the restricted list of ASC-eligible heart procedures. Cardiac specialty hospital revenues are reported in later sections for illustrative purposes.

The primary data file used in this analysis was the 2004 100% outpatient claims file. From this file, we extracted all of the Medicare fee-for-service outpatient claims for our current national census of cardiac, orthopedic, and surgical specialty hospitals. The 2004 census included 94 specialty hospitals with at least 45 percent of all Medicare charges in cardiac (MDC 5), orthopedic (MDC 8), or surgical Diagnostic Related Groups (DRGs); see Cromwell et al. 2005, for sampling details. After hospital deletions due to insufficient claims in 2004 and non-matches with outpatient claims, we had 20 cardiac, 43 orthopedic, and 12 surgical specialty hospitals for analytic purposes. Next, we reconfigured the outpatient claims to run through the ASC pricer. The hypothetical ASC payments were then merged back onto the specialty hospital outpatient data file by revenue center line item.

Using the ASC-repriced outpatient file, we compared Medicare's actual payment under outpatient prospective payment (OPPS) using hundreds of Ambulatory Patient Classes (APCs) with the payment specialty hospitals would have received under the 9-group ASC pricing system. The potential Medicare revenue gains inuring to a specialty hospital compared with an ASC were decomposed into four distinct revenue sources:

1. *Higher facility outpatient OPPS payments for specific, ASC-eligible, surgical procedures.*
2. *Higher OPPS payments for ancillary and medical services associated with an ASC-eligible procedure.* These payments were linked to patients with at least one positive ASC price on their claim.
3. *Higher OPPS payments for services not eligible for payment in an ASC.* These payments were for outpatient visits without any ASC payment.
4. *Payments for inpatient services.* These payments were based on RTI's study of 2004 inpatient claims for specialty hospitals (Adamache and Cromwell, 2006).

The first two revenue streams capture the direct outpatient revenue advantages of a specialty hospital compared with an ASC. To the extent that costs are equal across hospitals and ASCs for these procedures, the first revenue stream represents pure profits. (This assumption is discussed below when we draw conclusions from the findings.) Because we did not have ASC claims, we are not able to compare revenues and the mix of procedures directly between ASCs and SPHs. Thus, we cannot tell how important the revenue gains might be relative to the typical ASC's total revenue stream; only compared with an SPH's total revenues.

The third stream of non-ASC-eligible outpatient revenues are a mixture of medical and ancillary services not paid by Medicare in an ASC (e.g., MRIs) as well as procedures not done in ASCs (e.g., diagnostic catheterizations). The potential stream of inpatient revenues can play an

important role in physicians' decisions to invest in a specialty hospital rather than an ASC. They also serve to put the other outpatient revenue increases into perspective.

1.3 Summary of Findings

In 2004, orthopedic specialty hospitals (n=43) derived 58% of their Medicare revenues from inpatient services, on average, and 42% from outpatient services. Hence, as a group they tend to be less (not more) dependent on outpatient revenues than other hospitals their size.³ These facilities varied greatly, however, in their outpatient revenue shares with 10 having over 60% of their Medicare revenues from outpatient services and nine with less than 30%. Orthopedic hospitals highly dependent on Medicare outpatient revenues (i.e., shares greater than 60%) had double the outpatient revenues and only one-fifth the inpatient revenues of low dependent hospitals (i.e., shares less than 35%).

Surgical specialty hospitals (n=12) are far more dependent on outpatient revenues than orthopedic hospitals. Slightly over 70% of their Medicare revenues come from treating patients on an outpatient basis. This percentage is quite comparable to other hospitals in their 6–24 bedsize group (AHA, 2000, Table 4). All surgical specialty hospitals generated approximately the same dollar amount of Medicare outpatient revenues (\$1.8- \$1.9 million), but those highly dependent on such revenues generated only one-tenth the inpatient revenues of the least dependent group. Among surgical specialty hospitals, only two-in-12 derived less than 70% of the Medicare revenues from outpatient services.

Table 1 summarizes the four revenue sources that distinguish a specialty hospital from an ASC. Orthopedic specialty hospitals averaged \$1.6 million in Medicare outpatient OPPS revenues in 2004. Of this amount, almost four-fifths (\$1.2 million) were from procedures that were also eligible for payment in an ASC. When these procedures are repriced using ASC rates, the gain from OPPS over ASC prices averaged \$484,389, or 64% more than under ASC prices. The gain was 30% relative to all OPPS revenues and 12.7% of all Medicare revenues. In addition, orthopedic hospitals received an additional \$61,320 in OPPS payments for all other services associated with a procedure, i.e., medical visits, lab and radiology tests. These extra revenues, which are not paid for separately in ASC rates, comprised 3.8% of all OPPS revenues.

³ Orthopedic specialty hospitals generally have less than 50 inpatient beds. In 1998, short-term general and specialty hospitals averaged 56 percent inpatient gross revenues compared with 58 percent orthopedic SPHs (AHA, 2000, Table 4).

Table 1
Decomposition of orthopedic and surgical specialty hospital outpatient and inpatient Medicare revenues incorporating ASC repricing, 2004

	Orthopedic (N=43)		Surgical (N=12)	
	Mean \$	Outpatient Percent	Mean \$	Outpatient Percent
Outpatient revenues				
ASC-eligible procedures ^a				
1. Paid under OPPS	\$1,246,210	77.8	\$1,149,674	61.1
2. Repriced under ASC ^b	-761,821		-804,368	
3. Repricing gain	484,359	30.2	345,306	18.3
4. “Ancillary” OPPS payments for ASC-eligible procedures ^c	61,320	3.8	68,434	3.6
5. OPPS payments for services ineligible in an ASC ^d	294,942	18.4	662,837	35.3
6. Total OPPS revenues	1,602,471	100.0	1,880,945	100.0
7. Inpatient revenues	2,214,602		739,929	
8. Total facility revenues	3,817,074		2,620,874	

NOTES: ^aPayments for OPPS line items with ASC-eligible HCPCS codes.

^bPayments for procedure line items using ASC prices.

^cIncludes all HCPCS payments besides payments for the surgical procedure during same visit.

^dPayments for all services not covered in an ASC.

SOURCE: NCH 2004 Version I outpatient claims; 2004 BESS.

Orthopedic specialty hospitals also received \$294,942 in OPPS payments for outpatient visits with no ASC-eligible procedure. Laboratory and radiology services in CPT codes 70,010–89,350 comprised \$163,000 of these additional ancillary and ASC-ineligible revenues.⁴ Various MRI scans were the top five HCPCS procedures in this non-ASC-eligible category.

Orthopedic specialty hospitals generated an additional \$2.2 million, on average, in Medicare inpatient revenues. When added to outpatient revenues, total Medicare payments

⁴ This figure also includes related payments for ASC-eligible visits as well.

averaged \$3.8 million. Every \$1 in Medicare outpatient revenues were associated with \$1.40 in inpatient revenues.

Surgical specialty hospitals average slightly more Medicare outpatient revenues (\$1.9 million) than do orthopedic hospitals, although their total Medicare revenues are approximately 30% less when inpatient revenues are also included. For every \$1 in outpatient revenues, these hospitals generated \$0.39 in inpatient revenues. Of total Medicare outpatient revenues, 61% come from individual procedures also eligible for payment in ASCs. When repriced using ASC rates, the gain from OPSS over ASC prices for the procedures, alone, is \$345,306. This amounts to a 43% increase over ASC-based revenues. The repricing gain was 18.3% relative to all OPSS revenues and 13.2% of all Medicare revenues. The OPSS-ASC repricing gain is much smaller in percentage terms for surgical than orthopedic hospitals. The primary reason is that surgical specialty hospitals perform a less costly mix of outpatient surgery than do orthopedic hospitals. In addition to the repricing gain, surgical hospitals receive an additional \$68,434, on average, from other services provided during the visit involving an ASC-eligible procedure.

What particularly distinguishes a surgical from an orthopedic specialty hospital outpatient service are the services provided beneficiaries not having any ASC-eligible procedure. These extra Medicare revenues amounted to \$662,837, on average, or over one-third of all of their Medicare outpatient revenues and one-quarter of all their Medicare revenues. Radiology services, alone, accounted for \$313,000 of their non-ASC-eligible outpatient payments. CT and MRI scans were the top five HCPCS revenue generators for patients not undergoing an ASC-eligible procedure.

1.4 Conclusions

Based on RTI's findings,

- *Higher payments under the OPSS versus ASC payment systems for the same procedure may provide financial incentives to open or convert an ASC to an orthopedic or surgical specialty hospital.*

If no additional costs are incurred in performing the procedure in a specialty hospital versus an ASC, the higher observed OPSS revenues over ASC payments constitute a pure profit gain. There are two limitations to our study, however. First, we were unable to control for the complexity of outpatients being treated in the specialty hospital compared with an ASC. It is possible that orthopedic and surgical specialty hospitals treat more complex outpatients than do ASCs for particular procedures. This should increase specialty hospital costs. A greater limitation is the lack of control for procedure-mix. It is likely that specialty hospitals are performing a more complex, and costly, mix of procedures with higher OPSS payments than do ASCs. Consequently, part of the “gain” of being a specialty hospital may be in having inpatient beds to back up more complex outpatient surgery; beds that raise “stand-by” inpatient costs for outpatient surgery.

- *Medicare outpatient payment differentials in all (and not just specialty) hospitals compared with ASCs provide additional incentives for physicians and other investors to establish specialty hospitals. Because this incentive exists across all hospitals, a more fundamental and equitable correction would be to narrow the rates paid in different locations for the same procedure.*

As long as Medicare pays facilities different rates for the same procedure, providers will have incentives to promote one site of care over another. Any payment differences should be justified on quantifiable differences in patient complexity or type of procedure performed. Even with equal payment rates, specialty (and other) hospitals could still receive higher payments per procedure than ASCs if they performed more costly outpatient procedures on average.

- *Financial incentives to bill for services prohibited under the Stark self-referral laws are much greater in surgical versus orthopedic specialty hospitals, on average.*

Surgical specialty hospitals rely far more in both absolute and relative terms on outpatient services (particularly radiology) that would not be paid for in an ASC. Thus, the “self-referral” prohibition in ASCs may have encouraged some physicians to open (or convert an ASC to) a surgical specialty hospital.

- *Financial incentives from both OPSS-ASC pricing differentials and outpatient ancillary “self-referrals” together are minor for a subset of orthopedic specialty hospitals that are far less dependent on outpatient revenues.*

Orthopedic specialty hospitals are a particularly heterogeneous group in terms of their inpatient activity. One-quarter of them average 4.4-times the inpatient Medicare revenues of the least inpatient-oriented hospitals. Thus, one should not underestimate the dominant role of inpatient payment incentives for some specialty hospitals.

- *Prohibiting facilities where physicians have an ownership stake from providing ancillary services fails to address the underlying payment bias that encourages greater ancillary supply.*

Because physicians receive the same Medicare payment for their services regardless of location, the self-referral concern for ASCs versus specialty hospitals centers on the physician’s share of the facility payment. Given the strong growth in freestanding and hospital-based laboratory and radiology clinics, it appears from our repricing of outpatient procedures using ASC rates that Medicare is overpaying for the cost of providing such services to beneficiaries seen in hospitals. The outpatient payment differential is but another factor that encourages the development of the physician-owned specialty hospitals.

SECTION 2 METHODS AND DATA SOURCES

2.1 ASC Pricing Algorithms

Medicare reimburses ASC and hospital outpatient services under vastly different systems. Unlike Medicare's inpatient Prospective Payment System (IPPS) with over 500 DRGs and hundreds of outpatient (OPPS) Ambulatory Payment Classes (APCs), over 2,450 individual procedures (HCPCS codes) are uniquely assigned to one of just nine ASC payment classes (see Table 2). Average national facility payments range from \$333 for ASC Class 1 to \$1,339 for Class 9. Most classes bundle a few hundred procedures into a single average payment. Average payments per procedure will vary from hospital to hospital because of discounts for multiple procedures in the same visit. Payments are also adjusted by the hospital's area wage index.

Table 2
Payment rates and covered procedures by ASC payment class, 2003 and 2004

ASC Payment Class	Payment Rate	Number of Covered Procedures by Year	
		2003	2004
1	\$333	442	444
2	446	640	644
3	510	675	683
4	630	370	370
5	717	172	172
6	826	2	2
7	995	101	101
8	973	3	3
9	\$1,339	48	48
Total Procedures		2,453	2,467

SOURCE: Federal Register, May 4, 2005, p. 23,692.

Covered ASC procedures do not include evaluation and management (E&M) visits, lab tests, imaging, and other diagnostic tests. Also, ancillary procedures such as lab tests done at the ASC are considered as part of the bundle of services with no additional payment when performed. However, some items and procedures furnished in an ASC can be reimbursed separately and are not included in the fees in Table 2.⁵ For example, the ASC can bill the Medicare carrier for implantable durable medical equipment (DME), e.g., neurostimulators, prostheses. In other situations, the ASC can bill separately for ambulance services if the facility

⁵ See Chapter 14—Ambulatory Surgical Centers, of the Medicare Claims Processing Manual.

is approved as an ambulance supplier or for laboratory services if it has its own CLIA-certified independent laboratory.⁶

2.2 Outpatient Prospective Payment System (OPPS) Pricing Algorithms

Medicare’s hospital outpatient payment system (OPPS) is much more complex than for ASCs. First, there are currently about 820 APCs instead of just nine ASC rates. Second, multiple APCs may appear on one claim with separate payments, some of which may require diminished payment. Third, many medical and ancillary APCs without a procedure are not eligible for payment in an ASC. Fourth, several types of services on a hospital outpatient claim are paid for on a fee schedule or other payment system. These include ambulance services; clinical diagnostic laboratory services, non-implantable prosthetic and orthotic devices, EPO for ESRD patients; physical, occupational, and speech therapy, routine dialysis services for ESRD patients, diagnostic mammography, and screening mammography. For purposes of this study, we ignored services not paid for under the OPPS because we did not have access to these claims in the short time frame of the project. Individual imaging and other procedures can be reimbursed differently on different claims depending upon their service and payment status codes:

<u>OPPS Service</u>	<u>Description</u>
<u>Indicator</u>	
N	Packaged Incidental Service
S	Significant Procedure not subject to multiple procedure discount
T	Significant procedure subject to multiple procedure discounting
X	Ancillary service
<u>OPPS Payment</u>	
<u>Indicator</u>	
1	Paid standard hospital OPPS amount (service indicators S,T,V,X)
9	No additional payment, payment included in line items with APCs.

Some radiological exams, for example, have status indicators S or X, indicating separate APC payment. Likewise, some echography procedures have stand-alone service indicator S implying additional payment while others are given an N status indicating that their payment is bundled into an APC rather than paid for separately. In general, the more costly non-surgical procedures are paid separately under the OPPS, thereby enhancing total hospital payments relative to ASC payments. Sometimes these extra payments will be associated with a claim that also has an ASC-eligible procedure; if not, they appear as non-ASC-eligible payments.

2.3 File Construction

The primary dataset for this analysis was the 2004 100% Outpatient NCH version I file that contains all hospital outpatient visit claims for Medicare fee-for-service beneficiaries in 2004. To construct the analytic file, we first selected all outpatient claims for all physician-

⁶ However, the Stark laws limit the financial benefit of an ASC from owning a clinical lab because ASC physicians have limited ability to refer to a clinical lab in which they have partial ownership.

owned specialty hospitals in our “national” census that contained 94 hospitals as of December, 2004.⁷ We identified specialty hospital claims using the institutional provider identification number (PROVNUM). We then limited our analysis to claims where Medicare was the primary payor. As a result, we excluded approximately 1.75 percent of the outpatient claims.

Next, because the CMS “pricer” program for ASC claims is not designed to accept OPSS claims, it was necessary to reconfigure the outpatient claims consistent with the ASC pricer input format. The key inputs to the ASC pricer program are the provider, state, revenue center codes, service line count, the HCPCS codes, HCPCS modifiers, MSA code, MSA Lugar code, and admission (from) date. As part of this step, we added two additional variables to the OPSS claims that the ASC pricer required: (1) the hospital’s MSA wage index; and (2) the MSA Lugar code. Both come from the Inpatient Provider PROV file.⁸

After resolving several challenges in preparing the outpatient claims for the ASC pricer, we performed many checks to verify our programming. In one check, we manually repriced several outpatient claims and then compared the results with the pricer output. In a second check, we verified that the program was assigning each HCPCS in the outpatient claims to the proper ASC group by using the *ASC2004codes.xls* file on the CMS website. We also verified that the ASC pricer was discounting multiple procedures appropriately.

After testing the ASC pricer for accuracy, we created an analytical file by merging the ASC prices back onto the outpatient claims data by claim ID and revenue center.⁹ In contrast to the ASC pricer program, the hospital outpatient payment system reports program and beneficiary obligations separately. For comparability, we summed OPSS hospital payments, beneficiary co-payments, and deductibles by revenue center then compared them with total program and beneficiary payments from the ASC pricer program. Note that co-pays explain some of the difference between ASC and OPSS pricing. Under the ASC fee schedule, co-pays are 20 percent of the fees. Under the OPSS, co-pays are subject to the BBA changes that require co-pays to be initially set at 20 percent of the national median.¹⁰ The effective co-pay percentage in the OPSS claims used in this analysis is approximately 30 percent.

⁷ Three additional specialty hospitals were added to our Census since the 2005 Report to Congress based on an updated of the Medicare Provider of Services File.

⁸ A few hospital provider numbers were either not in the PROV file or did not have wage index MSAs. These providers were assigned their geographic MSA as the wage index MSA.

⁹ To merge the ASC pricer data back onto the outpatient claims, we first created a counter for each outpatient revenue center line item on each claim. The ASC pricer outputs the data in the same order it is received. We then used the counter to merge the ASC pricer data back to the appropriate claim ID and revenue center.

¹⁰ Section 4523 of the BBA also changed the way beneficiary coinsurance is determined for the services included under the PPS. A coinsurance amount will initially be calculated for each APC based on 20 percent of the national median charge for services in the APC. The coinsurance amount for an APC will not change until such time as the amount becomes 20 percent of the total APC payment. In addition, Section 204 of the BBRA provides that no coinsurance amount can be greater than the hospital inpatient deductible in a given year. See <http://www.cms.hhs.gov/HospitalOutpatientPPS/>.

2.4 Limitations to ASC Repricing

Any comparison of provider incentives under the OPSS and ASC payment systems is not straightforward and will have limitations. First, it is difficult to directly compare payment for *specific* services in the outpatient facility or ASC. Under OPSS, sometimes the same service is packaged and not paid separately while at other times it is paid separately. By contrast, the ASC payment system pays a single price for packaged services that varies in content, not only by HCPCS procedure but by any ancillary services provided by individual facilities as well. Therefore, we could not be entirely sure what extra services were provided beyond the surgical procedure. Payments may be discounted or not paid at all under both OPSS and ASC pricing if the same procedure is performed multiple times. At best, we can compare payments aggregated across Medicare patients.

Second, because inpatient beds can be used for treating surgical complications, specialty hospitals provide services in an outpatient setting that an ASC would not due to surgical risk. Hence, using just OPSS claims, we sometimes calculate a pricing differential for a procedure where, *de facto*, one does not exist as ASCs perform few, if any, of the particular procedures. We refer to these services as *non-ASC services* in our analyses.

Finally, we can not compare the marginal increase in *profits* to the specialty hospital under ASC pricing because we do not have actual cost data in either facility type. Additional outpatient ancillary revenues in a specialty hospital clearly overstate total profitability given the costs incurred in providing the service—costs generally not incurred by ASCs who refer patients elsewhere for testing.

2.5 Sources of Outpatient—ASC Revenue Differences

The marginal revenue gain to converting from an ASC to a specialty hospital was decomposed into four distinct revenue streams:

1. *Higher facility outpatient OPSS payments for specific, ASC-eligible, surgical procedures.* This difference was based on OPSS claim line items with positive ASC prices attached.
2. *Higher OPSS payments for ancillary and medical services paid for separately on claims with an ASC-eligible procedure.* These payments were linked to patients with at least one positive ASC price on their claim.
3. *Higher OPSS payments for services not eligible for payment in an ASC.* These payments were for outpatient claims without any ASC-eligible payment.
4. *Additional payments for inpatient services.* These payments were based on RTI's companion study of 2004 inpatient claims for specialty hospitals (Adamache and Cromwell, 2006).

These four enhanced SPH revenue streams from ASC outpatient repricing, $\Delta\text{REV}[\text{SPH v. ASC}]$, can be written as the following:

$$(1) \quad \Delta\text{REV}[\text{SPH v. ASC}] = \Delta\text{OREV}_{\text{ascproc}} + \Delta\text{OREV}_{\text{ascproc, other}} + \Delta\text{OREV}_{\text{non-ASC}} + \Delta\text{IREV}$$

$$(2) \quad \Delta\text{OREV}_{\text{ascproc, other}} = \Delta\text{OREV}_{\text{ascanc}} + \Delta\text{OREV}_{\text{ascmed}} + \Delta\text{OREV}_{\text{ascsproc}}$$

$$(3) \quad \Delta\text{OREV}_{\text{non-asc}} = \Delta\text{OREV}_{\text{non-asc, anc}} + \Delta\text{OREV}_{\text{non-asc, med}} + \Delta\text{OREV}_{\text{non-asc, sproc}}$$

A hospital will be paid differently than an ASC for performing a particular surgery. The difference is attributable to the payment differential between the OPPS and the ASC ($\Delta\text{OREV}_{\text{ascproc}}$) for the procedure line item plus any other associated payments on the ASC-eligible claim ($\Delta\text{OREV}_{\text{ascproc, other}}$). These extra revenues are for other ancillary ($\Delta\text{OREV}_{\text{ascanc}}$), medical ($\Delta\text{OREV}_{\text{ascmed}}$) and special procedure ($\Delta\text{OREV}_{\text{ascsproc}}$) services on the claim. In addition, an SPH receives outpatient revenues from patients that are never paid for in an ASC ($\Delta\text{OREV}_{\text{non-asc}}$). These patients could include those undergoing non-ASC special procedures such as diagnostic catheterization or other ancillary and medical services. SPHs would generate more revenues than an ASC simply because of their reimbursed for inpatient stays (ΔIREV). From our case study interviews completed as part of our separate study of specialty hospitals (Cromwell, et al., 2005), potential inpatient revenues were important in the decision either to convert or open a specialty hospital. Inpatient revenues are also used to calculate specialty hospital outpatient revenue shares that show how dependent they are on their outpatient services.

In our analysis, we further distinguish between a “broad” and “narrow” definition of “ancillary” revenues. Our narrow definition includes only laboratory and radiology HCPCS codes (70,010–89,350). Our broad definition also includes medical (99,000 series) and special procedures (90,000–98,999). Note that the narrow and broad ancillary definitions include payments for both ASC-eligible and ineligible claims, but differ in that the narrow definition excludes medical and special procedures.

SECTION 3
COMPARISON OF ACTUAL WITH ASC REPRICED OUTPATIENT SERVICES

In this section, we present and discuss the findings from our repricing of specialty hospital outpatient claims. To put the gains from outpatient payments in perspective, we first analyze the importance of outpatient revenues to the specialty hospitals' total revenue stream including inpatient revenues. We then present the results of the outpatient claim repricing by component.

3.1 Outpatient Revenue Shares

For this analysis, we defined Medicare specialty hospital revenues as the sum of total facility inpatient and outpatient payments claims. We stratified differences in (repriced) outpatient hospital payments¹¹ by type of specialty hospital because we expect cardiac, orthopedic, and surgical hospitals to have very different case mixes and rely to a greater or lesser degree on outpatient revenue. Systematic differences by type of hospital, if ignored, might over- or understate the incentive to convert from an ASC to a specialty hospital.

Table 3 presents summary statistics on the outpatient share of total Medicare revenues by type of specialty hospital. Outpatient payments shares vary systematically across hospital type from only 12 percent for cardiac hospitals to more than 70 percent for surgical hospitals. Orthopedic SPH outpatient payments comprise 42 percent of total facility Medicare payments.

Table 3
Specialty hospital outpatient share of total Medicare revenues, 2004

Type of hospital	Number of hospitals	Mean (%) Share	Median (%) share	Minimum share (%)	Maximum share (%)
Cardiac	20	11.8%	11.4%	4.9%	28.0%
Orthopedic	43	42.0%	45.1%	9.2%	84.9%
Surgical	12	71.8%	78.1%	47.9%	97.4%

NOTE: 2 specialty hospitals did not have both inpatient and outpatient claims. These were for provider numbers 170183 and 450315.

SOURCES: NCH Version I 2004 outpatient claims, RTI specialty hospital list. Computer output: dh7aPctbl_all.xls, outpatient_shares.lst, spec041p1.xls, spec04p2.xls, spec04n3.xls.

On average, orthopedic and surgical specialty hospitals receive three to six times more of their facility payments from outpatient care than do cardiac hospitals. Surgical hospitals, in particular, rely on outpatient services for the vast majority of their revenues. As a result,

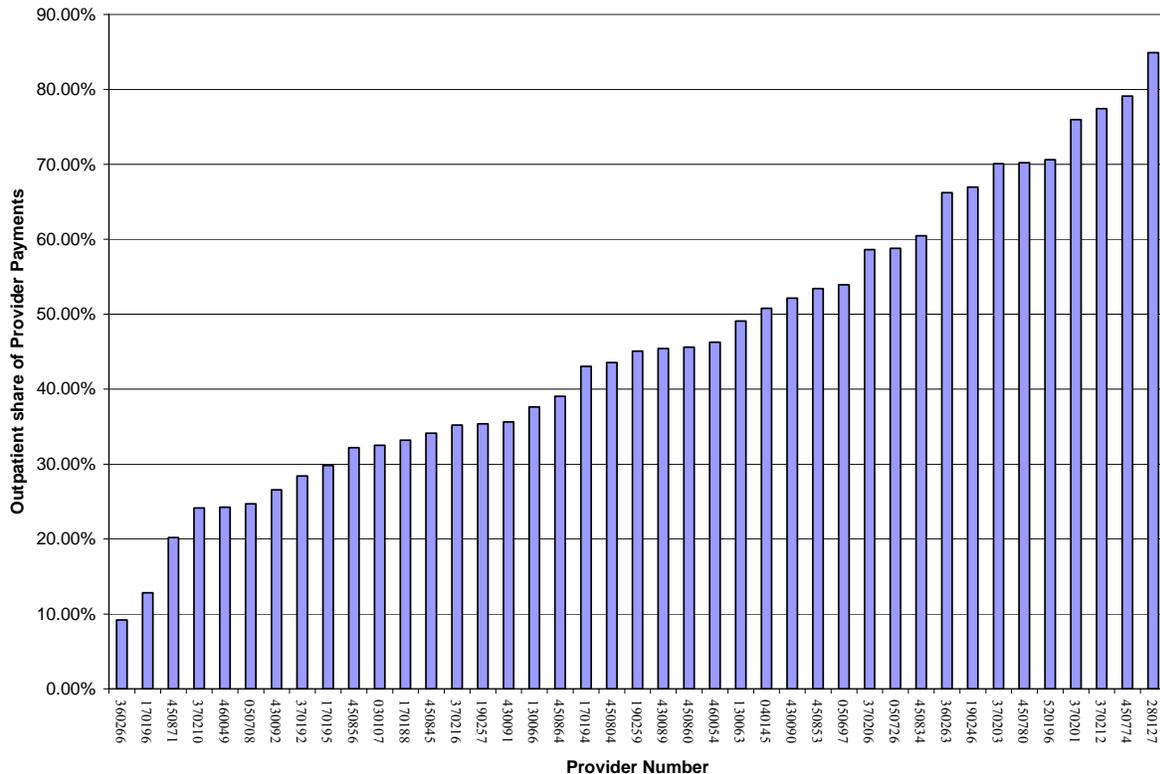
¹¹ The hospital may receive some additional payments for DME or other services not found on either the inpatient or outpatient claims. Services not paid for under OPPS are excluded.

orthopedic and surgical hospitals' revenue streams could be significantly impacted by any differences in outpatient and ASC pricing.

Averages can mask the variation in an individual specialty hospital's reliance on outpatient revenues. As the minimum and maximum shares in Table 3 show, there is significant variation even within a group of specialty hospitals. Figures 1 and 2 graph the distribution of outpatient shares for 43 orthopedic and 12 surgical specialty hospitals respectively. Orthopedic hospitals outpatient shares of Medicare revenues range from a low of 9 percent to a high of 85 percent. Some of the variation may be explained by service mix. Some orthopedic hospitals specialize in hip and knee surgery while others specialize in back surgery that requires less inpatient care. This variation in outpatient focus also suggests considerable variation in financial incentives to convert ASCs into specialty hospitals.

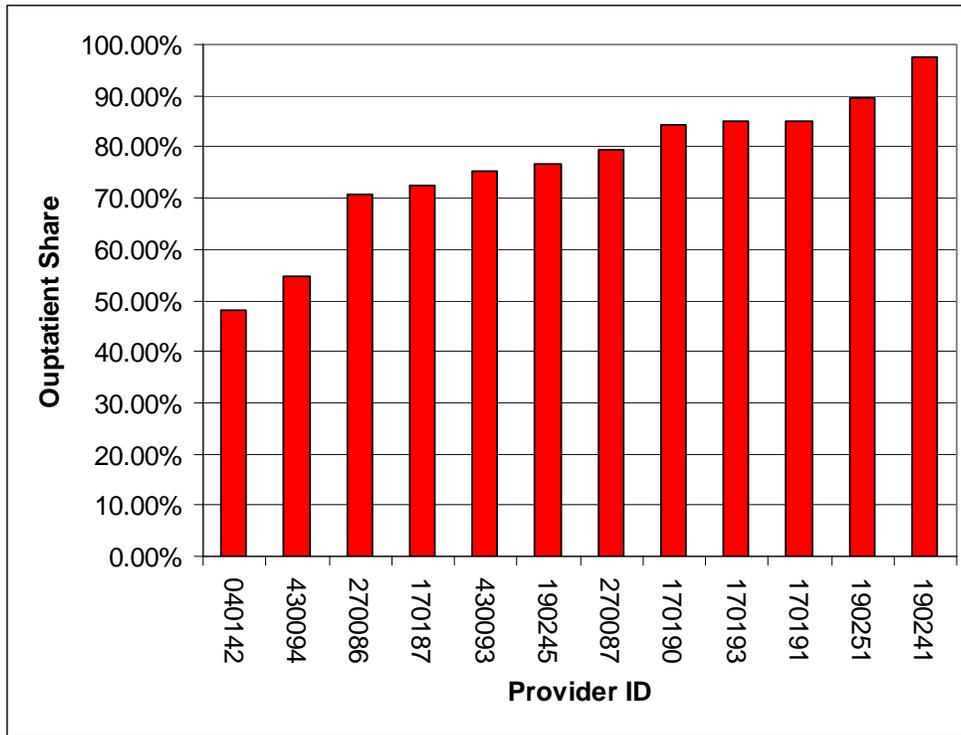
Surgical hospitals, on average, rely more on outpatient than inpatient services for their Medicare revenues, but there was still some variation (Figure 2). Surgical hospital outpatient shares of Medicare revenues range from a low of 47 percent to a high of 97 percent. However, the data show that only two surgical hospitals have outpatient shares of less than 60 percent. A closer investigation of these two surgical hospitals suggests that they could have been classified as orthopedic hospitals in a different time period.

Figure 1. Orthopedic specialty hospitals: outpatient share of Medicare total revenues, 2004



Source: NCH Version I 2004 outpatient claims, ASC Pricer Version V05.1, and RTI Specialty Hospital list.

Figure 2. Surgical specialty hospitals: outpatient share of Medicare total revenues, 2004



SOURCES: NCH Version I 2004 outpatient claims, RTI specialty hospital list. Computer output: dh7aPCtbl_all.xls, outpatient_shares.lst, spec041p1.xls, spec04p2.xls, spec04n3.xls.

Outpatient shares could vary within specialty hospitals either because Medicare inpatient revenues vary or outpatient activity is especially large for a given level of inpatient care.¹² Table 4 shows allowed charges by hospital type and outpatient share of Medicare revenues. As Table 4 shows, the difference in specialty hospital reliance on Medicare outpatient revenues is more a function of higher inpatient revenue than higher outpatient revenue. Cardiac and orthopedic specialty hospitals with low outpatient shares averaged about one-half the outpatient revenues of high share hospitals, but their inpatient revenues were 2.2 and 4.4-times greater, respectively. In surgical specialty hospitals, the entire difference in outpatient shares is explained by the amount of inpatient activity.

¹² A hospital's outpatient share (OSHARE) is a non-linear function of the ratio of inpatient (IREV) to outpatient (OREV) revenues:

<u>IREV/OREV</u>	<u>OSHARE</u>
15/5	.25
10/7	0.41
5/5	0.50
1/2	0.67
1/5	0.83
1/10	0.91

Table 4
Average Medicare payments by hospital type and Medicare share of outpatient revenues, 2004

Hospital type	Outpatient share	Inpatient allowed payments	Outpatient payments	Total payments	Number of hospitals
Cardiac	High: Greater than 20%	\$15,588,123	\$4,875,731	\$20,463,853	3
	Medium: 10–20%	24,482,686	3,486,822	27,969,508	12
	Low: Less than 10%	34,319,700	2,437,906	36,757,606	5
Orthopedic	High: Greater than 60%	790,753	2,027,617	2,818,371	11
	Medium: 35–60%	2,166,054	1,682,166	3,848,220	19
	Low: Less than 35%	3,490,353	1,126,255	4,616,608	13
Surgical	High: Greater than 85%	136,324	1,936,868	2,073,192	2
	Medium: 75–85%	491,010	1,910,582	2,401,592	6
	Low: Less than 75%	1,415,110	1,808,529	3,223,639	4

NOTE: Two specialty hospitals did not have both inpatient and outpatient claims. These were provider numbers 170183 and 450315.

SOURCES: NCH Version I 2004 outpatient claims, RTI specialty hospital list. Computer output: dh7aPCtbl_all.xls, outpatient_shares.lst, spec041p1.xls, spec04p2.xls, spec04n3.xls.

3.2 Repricing ASC-Covered Procedures

The first source of potential financial gain from OPPS pricing comes from higher average outpatient payments for the specific procedures eligible for payment under ASC pricing. We call these ASC-covered HCPCS procedures. There can be large differences in payments for a specific procedure between the OPPS and ASC pricing systems, and OPPS payments for ASC-covered HCPCS do not consistently receive higher payments in the outpatient setting. The principal reason is that there are only nine ASC groups but more than 800 APC groups. As a result, within a single ASC class and payment amount, some procedures are paid for more and some far less.

Table 5 reports the procedure frequency and average OPPS payments relative to (hypothetical) ASC payments by nine ASC categories for each of the three types of specialty hospitals. The number of ASC-covered line item procedures ranged from a low of 3,595 in cardiac specialty hospitals to 75,228 in orthopedic hospitals. Average OPPS increases over ASC prices ranged from 43 percent in surgical hospitals to slightly over 60 percent in both cardiac and orthopedic hospitals (see Total line). Higher OPPS payment differentials were greatest in ASC categories 3 and 4, ranging from 2.11 to 3.27, implying that, on average, OPPS procedure payments were double to triple those received in an ASC. Of the 27 potential payment cells in Table 5 (nine categories by three specialty hospital types), 13 had OPPS/ASC payment ratios of 1.5 or greater, and only two had ratios less than 1.0. By contrast, OPPS payments for nearly one-half of all cardiac procedures (see category 2) averaged less under ASC payment. OPPS/ASC payment ratios were lowest in ASC category 1 for orthopedic and surgical specialty hospitals.

Table 5
Percent of Medicare outpatient cases and the ratio of OPPS average procedure payments^a
over ASC payments^b by ASC category by type of specialty hospital, 2004

ASC Category	Cardiac (N=3,595)		Orthopedic (N=75,228)		Surgical (N=18,749)	
	% Cases	\$OPPS/\$ASC ^c	% Cases	\$OPPS/\$ASC ^c	% Cases	\$OPPS/\$ASC ^c
1	17.6%	1.49	50.7%	1.04	16.7%	0.95
2	49.2	0.95	15.7	2.65	38.6	1.29
3	10.4	3.27	10.6	2.81	11.5	2.37
4	19.4	2.76	6.8	2.10	8.0	2.11
5	1.6	1.74	3.6	1.73	3.2	1.64
6	0.0	--	0.1	1.33	0.1	1.25
7	0.3	1.23	1.3	1.92	1.7	1.82
8	0.0	--	10.7	1.25	19.8	1.20
9	1.6	1.34	0.5	1.04	0.4	1.02
Total	100.0	1.65	100.0	1.61	100.0	1.43

NOTES: ^aIncludes only OPPS line item procedures eligible for ASC payment. Excludes other “ancillary” APC payments on claims.

^bASC “payments” exclude any extra DME device payment that may or may not be included in the OPPS line item payment.

^cRatio of volume-weighted average OPPS versus “repriced” ASC payment.

N=total number of procedure line items.

SOURCE: NCH 2004 Version I outpatient claims; ASC Pricer Version VO5.1: computer run: GC32TBL6.

In terms of procedure volumes, two-thirds of orthopedic procedures performed in a specialty hospital outpatient department would be paid under the two lowest paying ASC categories compared with 55 percent in surgical hospitals. This difference is explained by the fact that as many as one-in-five procedures in surgical specialty hospitals were in the high-paying ASC category 8 (eye procedures).

Systematically higher paid procedures under OPPS versus ASC payment systems differs from results published by Winter (2003) who found that “ASC rates are higher than outpatient department rates for eight of the ten procedure codes with the highest share of Medicare payments to ASCs” (p. 69). We believe that the primary reason for the difference is due to the service mix. Of Winter’s top 10 ASC procedures, only four were in the top 10 procedures performed in a specialty’s hospital’s outpatient department. Specialty hospitals tend to perform procedures in the higher paid ASC categories where the absolute dollar difference in OPPS and

ASC rates are greatest. Specialty hospitals likely are able to perform more complex and costly procedures because they have inpatient beds for “back-up” care.¹³

Tables 6, 7, and 8 provide detailed information on the three highest volume SPH procedures in each ASC category type of specialty hospital. As expected, high volume cardiac outpatient procedures, even within ASC category, are generally different than those in the other two hospital types. By contrast, high volume procedures in orthopedic and surgical hospitals are quite similar, implying that the criteria used to distinguish them has limited meaning for policy purposes. For example, orthopedic specialty hospitals performed nearly 7,900 cataract removals and lens insertions (66984), or double the number in surgical specialty hospitals. (There were 3.5 times more orthopedic than surgical hospitals.)

Regarding payment differentials, it is not obvious why many procedures should be paid double or more in a hospital’s outpatient department versus an ASC. For example, a carpal tunnel neuroplasty (64721) is paid more than double in an orthopedic hospital (Table 7) versus an ASC. The same is true of an abrasion knee arthroplasty (29881) and a partial claviclectomy excision (23120). For several other procedures, however, the payment differential is likely more apparent than real because the ASC payment does not include the device cost, which is paid separately under durable medical equipment or prostheses. These devices could include neurostimulators (ASC 2, 63650, orthopedic hospitals), drug delivery systems (ASC 7, 67040, orthopedic hospitals), and central venous devices (ASC 3, 36561, surgical hospitals). Prostheses may also be paid for separately in an ASC (ASC 7, 23420, orthopedic hospitals).

Table 9 shows the aggregate difference in average total payments per hospital for ASC-covered HCPCS procedures (line items) under OPPS pricing and ASC pricing. One caveat to this comparison is that it only compares payments on HCPCS that are paid separately and not grouped into another APC for additional payment. On net, cardiac specialty hospitals enjoy a 44 percent average gain in payment (\$63,663) for the procedure alone compared with ASCs. Orthopedic SPHs enjoy a comparable 39 percent increase (\$484,389) while surgical SPHs experience a lower 30 percent gain (\$345,306).

¹³ Other more minor payment differences are due to our use of 2004 claims versus 2003 for Winter, our sample being limited to specialty hospitals, and Winter’s ASC payments possibly not adjusted for geographic price inflation. We found only 5-in-10 of Winter’s top 10 ASC procedures were actually paid less in ASCs than in specialty hospitals in 2004. Unpublished analysis by CMS staff shows that systematic overpayment in ASCs versus hospital outpatient departments does not exist when considering the differing mix of procedures performed in OPPS-paid hospitals versus ASCs.

Table 6
Three highest-volume OPPS v. ASC repriced procedures by ASC category:
Cardiac specialty hospitals

ASC Category	HCPCS	Procedure Description	# Procedures	Average Payment		Ratio OPPS/ASC
				OPPS	ASC	
1	64483	Inject lumbar anesthetic	116	\$338	\$328	1.03
	43235	Upper GI endoscopy	114	351	281	1.25
	36569	Insert venous catheter	60	954	322	2.96
2	11042	Skin debridement	522	144	400	0.36
	43239	Upper GI endoscopy w/biopsy	204	358	437	0.82
	45378	Colonscopy, flexible	196	431	402	1.07
3	36821	Venous anastomosis, any site	130	1,901	507	3.75
	36819	Venous anastomosis, upper arm	62	1,798	490	3.67
	37607	Ligation arteriovenous fistula	43	1,050	402	2.61
4	36831	Thrombectomy	194	1,530	600	2.55
	36833	Revision arterio fistula	188	1,810	621	2.92
	36830	Vein graft, non-autogenous	123	1,823	628	2.90
5	36870	Thrombectomy	47	1,232	720	1.71
	25620	Radial fracture, open	2	1,688	697	2.42
	26587	Reconstruction, digit tissue & bone	2	811	716	1.13
7	23412	Repair rotator cuff, chronic	3	1,483	975	1.52
	49520	Repair inguinal hernia, recurrent, reducible	3	1,447	992	1.46
	49568	Implant prosthesis for hernia repair	3	729	1,003	0.73
9	55859	Inject anesthesia, sacroiliac	53	1,796	1,325	1.36
	49507	Repair inguinal hernia, strangulated	2	1,469	1,338	1.10
	49561	Repair ventral hernia, strangulated	1	1,404	1,304	1.08

NOTES: No cardiac specialty hospitals billed for procedures in ASC categories 6 and 8.

SOURCE: NCH 2004 Version I outpatient claims; ASC Pricer Version VO5.1: computer run: GC32TBL6.

Table 7
Three highest-volume OPPS v. ASC repriced procedures by
ASC category: Orthopedic specialty hospitals

ASC Category	HCPCS	Procedure Description	# Procedures	Average Payment		Ratio OPPS/ASC
				OPPS	ASC	
1	62311	Inject anesthetic/antispasmodic, single	10,770	\$267	\$319	0.84
	64483	Inject lumbar anesthetic, single lumbar	6,061	338	327	1.03
	64476	Inject lumbar anesthetic, single cervical/thoracic	3,503	219	252	0.87
2	64721	Carpal tunnel neuroplasty	1,754	798	389	2.05
	43239	Upper GI endoscopy w/biopsy	1,012	350	433	0.81
	63650	Percutaneous neurostimulator implant, epidural	763	2,844	380	7.48
3	29826	Shoulder arthroscopy, decompression	1,124	2,251	283	7.94
	28285	Correction hammertoe	1,121	590	340	1.74
	20680	Removal of implant wire/pin, deep	424	863	465	1.86
4	29881	Abrasion knee arthroplasty, medial, w/meniscectomy	1,223	1,356	580	2.34
	29880	Abrasion knee arthroplasty, med & lat, w/meniscectomy	788	1,349	578	2.33
	29877	Knee arthroscopy w/debridement of cartilage	225	646	589	1.10
5	29827	Shoulder arthroscopy, w/rotator cuff repair	500	769	579	1.33
	29824	Shoulder arthroscopy, Mumford procedure	496	737	625	1.18
	23120	Claviclectomy, excision, partial	228	1,057	500	2.12
6	66985	Insert interocular lens w/o cataract removal	42	1,061	799	1.33
	66986	Exchange of interocular lens	23	1,041	784	1.33
7	23412	Repair rotator cuff, chronic	371	1,793	979	1.83
	23420	Shoulder reconstruction, complete	164	2,129	977	2.18
	67040	Intravitreal Drug delivery system, w/laser coagulation	86	1,991	913	2.18
8	66984	Extracapsular cataract removal, w/lens insertion	7,891	1,198	957	1.25
	66982	Extracapsular cataract removal, complex, w/lens insertion	184	1,177	950	1.24
	66983	Intracapsular cataract removal, w/lens insertion	4	1,043	953	1.10
9	29848	Carpal ligament endoscopy, wrist	193	1,467	1,365	1.07
	62287	Aspiration/decompression, lumbar	56	799	1,305	0.61
	55859	Inject anesthesia, sacroiliac	43	1,757	1,313	1.34

NOTES:

SOURCE: NCH 2004 Version I outpatient claims; ASC Pricer Version VO5.1: computer run: GC32TBL6.

Table 8
Three highest-volume OPPS v. ASC repriced procedures by ASC category:
Surgical specialty hospitals

ASC Category	HCPCS	Procedure Description	# Procedures	Average Payment		Ratio OPPS/ASC
				OPPS	ASC	
1	62311	Inject anesthetic/antispasmodic, single	1,368	\$253	\$310	0.81
	43235	Upper GI endoscopy, esophagus, stomach, diagnostic	304	311	255	1.22
	64475	Inject anesthetic, lumbar	169	345	375	0.92
2	45378	Colonoscopy, flexible to splenic flexure	1,019	396	389	1.02
	45384	Colonoscopy w/tumor removal	904	371	385	0.96
	43239	Upper GI endoscopy w/biopsy	824	319	414	0.77
3	29826	Shoulder arthroscopy, decompression	169	2,097	259	8.10
	28285	Correction hammertoe	147	555	342	1.62
	36561	Insert central venous device	133	1,194	465	2.57
4	29881	Abrasion knee arthroplasty, medial, w/menisectomy	236	1,257	560	2.25
	49505	Repair inguinal hernia, reducible	181	1,364	615	2.22
	29880	Abrasion knee arthroplasty, med & lat, w/menisectomy	124	1,280	577	2.22
5	29827	Shoulder arthroscopy, w/rotator cuff repair	77	694	554	1.25
	29824	Shoulder arthroscopy, Mumford procedure	69	677	633	1.07
	15823	Blepharoplasty, upper eyelid, excessive	67	840	851	0.99
6	66985	Insert interocular lens w/o cataract removal	9	980	783	1.25
	66986	Exchange of interocular lens	8	981	789	1.24
7	23412	Repair rotator cuff, chronic	109	1,899	939	2.02
	67040	Intravitreal Drug delivery system, w/laser coagulation	30	1,868	931	2.01
	49568	Repair umbilical hernia	28	628	888	0.71
8	66984	Extracapsular cataract removal, w/lens insertion	3,650	1,113	924	1.20
	66982	Extracapsular cataract removal, complex, w/lens insertion	63	1,093	913	1.20
9	29848	Carpal ligament endoscopy, wrist	25	1,323	1,262	1.05
	49587	Repair umbilical hernia, strangulated	15	1,049	1,265	0.83
	52648	Contact laser vaporization of prostate, complete	9	1,546	1,182	1.31

NOTES:

SOURCE: NCH 2004 Version I outpatient claims; ASC Pricer Version VO5.1: computer run: GC32TBL6.

Table 9
Average total Medicare payments for ASC-covered HCPCS procedures per specialty hospital under outpatient and ASC pricing, 2004

Specialty Hospital type	ASC-covered procedures ^a			
	OPPS Outpatient payment	ASC payment	Difference	OPPS to repriced ASC Payment (% increase)
Cardiac	\$144,702	\$81,038	\$63,663	44.1%
Orthopedic	1,246,210	761,821	484,389	38.9
Surgical	1,149,674	804,368	345,306	30.1

NOTE: Only includes claims where Medicare is the primary payor.

^aIncludes only procedure line items with positive ASC payment. Excludes ancillary and medical APC payments on claim.

SOURCES: NCH 2004 Version I outpatient claims, ASC Pricer Version V05.1, and RTI Specialty Hospital list. Computer output: dh5ePCtbl_all.xls

3.3 Repricing “Ancillary Services”

Next, we show how much of the payment differences are due to services that would never be paid for in an ASC. In Table 10, we compare total outpatient payments per hospital with payments for OPSS claims with at least one ASC-covered procedure. Also, instead of ASC repricing only for line items with an ASC-covered procedure, we now show (column 2) how much specialty hospitals were paid under OPSS for the *entire* claim that had an ASC-covered procedure. The difference between this amount and total outpatient payments represents payments for non-ASC-eligible patient visits. When payments are limited to claims for ASC-eligible patients, \$250,111 (7.3 percent) of cardiac hospital payments are for ASC-eligible patients. This amount is three times the gain from repricing only the procedure line item. The increase is from additional line item payments on the claims that are ineligible for payment in ASCs (e.g., imaging, lab tests). Subtracting outlays on all ASC-eligible claims for total OPSS payments leaves yet another \$3.18 million in OPSS payments on claims without any ASC-covered procedure. In contrast, 82 percent and 65 percent of orthopedic and surgical specialty hospital payments come from patients that could have been seen in an ASC—at least for the surgical procedure.

Table 10 shows substantial outpatient payments not specifically eligible for ASC payment. These extra payments are found on claims with or without an ASC-eligible procedure. In the next two sub-sections, we explore the sources of these extra payments in more detail. First, we isolate payments for all laboratory, radiology, and special services that appear in the 70,000-98,999 range of CPT codes.¹⁴ They still exclude surgeries not paid for in an ASC as well as all medical visits in CPT’s 99,000 series. These services constitute a *broad* definition of “ancillary” services. Second, we further isolate just laboratory and radiology services. These services comprise our *narrow* definition of ancillary services.

¹⁴ Special services include psychiatrist, ophthalmologist, and therapy visits; they also include dialysis, cardiovascular, auditory, and pulmonary tests, among others (e.g., cardiac catheterization).

Table 10
Average total Medicare outpatient payments per specialty hospital for claims with or without any ASC services, 2004

Hospital type	Total OPSS payments	Total OPSS payments on ASC–		ASC to OPSS payments
		eligible claims ^a	Non-ASC claims ^b	
Cardiac	\$3,432,929	\$250,111	\$3,182,818	7.3%
Orthopedic	1,602,471	1,307,529	294,942	81.6
Surgical	1,880,945	1,218,108	662,837	64.8

NOTE: Only includes claims where Medicare is the primary payor.

^aIncludes all OPSS payments for ASC-eligible procedures plus any ASC-ineligible medical and ancillary services on claim.

^bPayments on claims with no ASC–eligible procedure.

SOURCES: NCH 2004 Version I outpatient claims, ASC Pricer Version V05.1, and RTI Specialty Hospital list. Computer output: dh6aPctbl_all.xls.

3.3.1 “Broad Ancillary” Payments

In Table 11, we present the broad definition of ancillary payments for all outpatient claims versus just those payments on ASC-eligible claims.

Table 11
Medicare “ancillary” outpatient payments per specialty hospital, broad^a definition, 2004

Hospital type	All claims		ASC–eligible claims	
	“Broad Ancillary” payments ^b	Average share of all outpatient payments (%) ^c	“Broad Ancillary” payments ^b	Average share of ASC eligible payments (%) ^d
Cardiac	\$1,845,830	53.7%	\$20,108	24.8%
Orthopedic	229,753	14.4	22,271	2.9
Surgical	435,118	23.1	29,966	3.7

NOTES: Only includes claims where Medicare is the primary payor.

^aCPT codes 70,000-98,999 including lab, radiology, and special services.

^bIncludes both ASC-eligible and non-ASC-eligible claims.

^cColumn (1) divided by column (1) in Table 10.

^dColumn (3) divided by column (2) in Table 10.

SOURCES: NCH 2004 Version I outpatient claims, ASC Pricer Version V05.1, and RTI Specialty Hospital list. Computer output: dh56aPctbl_tbl1.xls, dh56aPctbl2_all2.xls

Broadly-defined ancillary payments from all Medicare outpatient claims account for approximately 14 percent of orthopedic and 23 percent of surgical specialty hospital outpatient revenues (col. 2). Cardiac hospitals had much higher payments for these “ancillary” services because they provide many more special services not provided in an ASC. When restricted to claims for patients who might have been seen in an ASC, orthopedic and surgical specialty hospital ancillary services are only 3–4 percent of repriced payments. Hence, practically all extra broad ancillary revenues come from patient visits that would not have been paid for at all in an

ASC. One reason for such a low percentage on ASC-eligible claims may be that many ancillary services, are not paid for separately in the outpatient facility when a procedure is performed.

Table 12 presents the five highest revenue-generating “broad” ancillary services for all outpatient claims (i.e., patients) and separately for just ASC-eligible claims. The leading ancillary services differ markedly between all outpatient claims and ASC-eligible claims. Orthopedic specialty hospitals received the most “ancillary” payments for physical therapy and MRIs while surgical hospitals provide more diagnostic catherizations, CT scans, and MRIs. However, on ASC-eligible claims that require a surgical procedure, cardiography, lab tests, and fluoroscopy were more common, albeit far smaller in terms of revenues than the first group of broad ancillaries without a surgical procedure.

Table 12
Medicare outpatient payments for top five “broad” ancillary services by specialty hospital type, 2004

Cardiac			Orthopedic			Surgical		
HCPCS	Description	Payments per hospital	HCPCS	Description	Payments per hospital	HCPCS	Description	Payments per hospital
				<u>All Claims</u>				
93510	Left heart catheterization, retrograde	\$631,385	97110	Physician or therapist required - therapeutic procedure one or more areas, each 15 minutes	\$24,961	93510	Left heart catheterization, retrograde	\$39,648
93526	Combined right heart catheterization and retrograde left heart catheterization	111,189	72148	MRI, spinal canal and contents without contrast material	20,852	72193	Computed tomography, pelvis, with contrast materials	22,719
75625	Aortography, abdominal, by serialography, radiological supervision and interpretation	59,005	72158	MRI, spinal canal and contents without contrast material followed by contrast materials and further sequences; lumbar	14,046	74160	Computed tomography, abdomen, with contrast materials	22,593
75716	Angiography, extremity, bilateral, radiological supervision and interpretation	45,604	73221	MRI, any joint of upper extremity; without contrast	8,353	72148	MRI, spinal canal and contents without contrast material	22,323
93651	Intracardiac catheter ablation of arrhythmic focus	45,480	97140	Physician or therapist required - manual therapy techniques (mobilization/manipulation, etc) one or more regions, 15 minutes each	8,336	71260	Computed tomography, thorax, with contrast material	20,761
				<u>ASC-Eligible Claims</u>				
77799	Unlisted procedure, clinical brachytherapy	1,940	72275	Epidurography, radiological supervision and interpretation	5,202	88305	Level IV- surgical pathology, gross and microscopic examination	8,217
93510	Left heart catheterization, retrograde	1,087	76000	Fluoroscopy, up to one hour physician time, other than 71023 or 71034	2,182	76000	Fluoroscopy, up to one hour physician time, other than 71023 or 71034	3,408
76000	Fluoroscopy, up to one hour physician time, other than 71023 or 71034	998	93005	Cardiography, tracing only without interpretation and report	1,426	76095	Stereotactic localization guidance for breast biopsy or needle placement	1,995
93005	Cardiography, tracing only without interpretation and report	904	97001	Physical therapy evaluation	950	93005	Cardiography, tracing only without interpretation and report	1,722
77470	Radiologic examination, renal cyst study, translumbar, contrast visualization, radiological supervision and interpretation	800	88305	Level IV- surgical pathology, gross and microscopic examination	737	90784	Intravenous Therapeutic, prophylactic or diagnostic injection	1,709

NOTE:

SOURCES: NCH 2004 Version I outpatient claims, ASC Pricer Version V05.1, and RTI Specialty Hospital list.

3.4.2 “Narrow Ancillary” Payments

In Tables 13 and 14, we present radiology and lab service payments to specialty hospitals. Radiology payments account for approximately 10 percent of orthopedic and 17 percent of cardiac and surgical specialty hospital total outpatient revenue. Radiology payments also comprise over two-thirds of our broad definition of ancillary payments. Lab payments accounted for less than 2 percent of total Medicare outpatient revenue in orthopedic and specialty hospitals and less than 10 percent of “broad” ancillary payments. Radiology and lab payments appearing on ASC-eligible claims accounted for less than 1.5 percent of Medicare payments on ASC-eligible claims in orthopedic and surgical specialty hospitals.

Table 13
Medicare radiology^a outpatient payments per specialty hospital, 2004

Hospital type	All claims		ASC-eligible claims	
	Radiology payments	Average radiology share of all outpatient payments (%) ^b	Radiology payments	Average radiology share of all ASC eligible Claim payments (%) ^c
Cardiac	\$586,009	17.1%	\$10,738	4.3%
Orthopedic	153,344	9.6	15,247	1.2
Surgical	312,826	16.6	12,272	1.0

NOTES:

^aRadiology HCPCS are 70010-79999.

^bColumn (1) divided by column (1), Table 10.

^cColumn (3) divided by column (2), Table 10.

SOURCES: NCH 2004 Version I outpatient claims, ASC Pricer Version V05.1, and RTI Specialty Hospital list.

Computer output: dh7apctbl_all.xls

Table 14
Medicare laboratory^a outpatient payments per specialty hospital, 2004

Hospital type	All claims		ASC-eligible claims	
	Lab payments	Average lab share of all outpatient payments (%) ^b	Lab payments	Average Lab share of all ASC-eligible claim payments (%) ^c
Cardiac	\$118,599	3.5%	\$4,100	1.6%
Orthopedic	9,823	0.6	3,464	0.3
Surgical	35,364	1.9	14,124	1.2

NOTES:

^aLab HCPCS are 80048–89350.

^bColumn (1) divided by column (1), Table 10.

^cColumn (3) divided by column (2), Table 10.

SOURCES: NCH 2004 Version I outpatient claims, ASC Pricer Version V05.1, and RTI Specialty Hospital list.

Computer output: dh7apctbl_all.xls

In Tables 15 and 16, we present the five highest revenue-generating radiology and lab services for all outpatient and ASC-eligible claims by specialty hospital type.

Table 15
Medicare outpatient payments for top five radiology services by specialty hospital type, 2004

Cardiac			Orthopedic			Surgical		
HCPCS	Description	Payments per hospital	HCPCS	Description	Payments per hospital	HCPCS	Description	Payments per hospital
				<u>All Claims</u>				
75625	Aortography, abdominal, by serialography, radiological supervision and interpretation	\$1,180,093	72148	MRI, spinal canal and contents, without contrast material, followed by contrast materials – cervical	\$854,910	72193	Computed tomography, pelvis; without contrast materials	\$227,192
75716	Angiography, extremity, bilateral, radiological supervision and interpretation	912,074	72158	MRI, spinal canal and contents, without contrast material, followed by contrast materials – lumbar	575,873	74160	Computed tomography, abdomen, with contrast materials	225,926
75960	Transcatheter introduction of intravasculat stents	703,387	73221	MRI, any joint of upper extremity, without contrast materials	342,473	72148	MRI, spinal canal and contents, without contrast material, followed by contrast materials - cervical	223,233
75680	Angiography, cartoid, cervical, bilateral, radiological supervision and interpretation	539,148	72141	MRI, spinal canals and contents, cervical, without contrast materials	335,137	71260	Computed tomography, thorax, with contrast materials	207,613
75630	Aortography, abdominal plus bilateral iliofmeoral lower extremity, catheter, by serioalography, radiological supervision and interpretation	519,348	73721	MRI, any joint of lower extremeity, without contrast materials	333,353	70553	MRI, brain (including brain stem); without contrast materials, followed by contrast materials	156,404
				<u>ASC-Eligible Claims</u>				
77799	Unlisted procedure, clinical brachytherapy	38,799	72275	Epidurography, radiological supervision and interpretation	213,303	76000	Floroscopy, up to one hour physician time	34,083
76000	Floroscopy, up to one hour physician time	19,969	76000	Floroscopy, up to one hour physician time	89,446	76095	Stereotactic localization guidance for breast biopsy or needle placement	19,947
77470	Special treatment procedure (e.g., total body irradiation, hemibody radiation, per oral, endocavitary or intraoperative cone irradiation)	16,191	76150	Xeroradiography	25,625	71010	Radiologic examination, chest single view, frontal	13,391
75978	Transluminal balloon angioplasty, each additional visceral artery, radiological supervision and interpretation	12,212	72020	Radiologic examination, spine, single view	24,965	74450	Urethrocytography, voiding, radiological supervision and interpretation	10,951
71010	Radiologic examination, chest single view, frontal	11,456	77778	Interstitial radiation source application, complex	22,566	74420	Urography, retrograde, with or without KUB	6,486

SOURCES: NCH 2004 Version I outpatient claims, ASC Pricer Version V05.1, and RTI Specialty Hospital list.
Computer output: dh7apctbl_all.xls

Table 16
Medicare outpatient payments for top five laboratory services by specialty hospital type, 2004

Cardiac			Orthopedic			Surgical		
HCPCS	Description	Payments per hospital	HCPCS	Description	Payments per hospital	HCPCS	Description	Payments per hospital
				<u>All Claims</u>				
83880	Natriuretic peptide	\$299,919	85025	Complete CBC, automated, and automated differential WBC count	\$57,661	88305	Level IV - surgical and microscopic examination	\$86,566
80048	Basic metabolic panel	250,726	80048	Basic metabolic panel	52,056	80053	Comprehensive metabolic panel	39,862
85025	Complete CBC, automated, and automated differential WBC count	189,186	80053	Comprehensive metabolic panel	38,867	84153	prostate specific antigen; total	32,562
84484	Troponin, quantitative	179,071	85999	Unlisted hematology and coagulation procedure	35,122	85027	Complete CBC, automated	24,553
82553	Creatine kinase, CPK; MB fraction only	176,988	88305	Level IV - surgical and microscopic examination	32,776	85025	Complete CBC, automated, and automated differential WBC count	21,007
				<u>ASC-Eligible Claims</u>				
80048	Basic metabolic panel	11,861	88305	Level IV - surgical and microscopic examination	30,218	88305	Level IV - surgical and microscopic examination	82,171
85027	Complete CBC, automated	5,747	80048	Basic metabolic panel	14,466	88342		12,648
85025	Complete CBC, automated, and automated differential WBC count	5,558	85025	Complete CBC, automated, and automated differential WBC count	12,530	88304	Level III - surgical pathology, gross and microscopic	8,238
83013	Helicobacter pylori, breath test analysis for urease activity, non-radioactive isotope	3,935	88304	Level III - surgical pathology, gross and microscopic	10,044	83013	Helicobacter pylori, breath test analysis for urease activity, non-radioactive isotope	7,117
83880	Natriuretic peptide	3,550	84132	Potassium; serum	9,107	88307	Level V- Surgical pathology, gross and microscopic examination	4,694

SOURCES: NCH 2004 Version I outpatient claims, ASC Pricer Version V05.1, and RTI Specialty Hospital list.

Computer output: dh7apctbl_all.xls

3.5 Repricing Medical Services

The third potential source of additional payments for specialty hospitals in the outpatient setting is payments for medical services such as generally evaluation and management office visits. As with ancillary services, medical visits and services are not eligible for separate facility payment in ASCs. As a result, all OPSS payments paid to the specialty hospital for medical services are a potential financial gain relative to the ASC facility payment.¹⁵

Medical payments (excluding physician payments) comprise a significantly smaller share of specialty hospital outpatient payments than do ancillary payments (see Table 17). In fact, the average orthopedic and surgical specialty hospital received less than \$6,000 in 2004, or one-fifth of one percent of their Medicare outpatient revenue from medical services. In addition, payments for medical services on ASC-eligible claims was almost non-existent, primarily because Medicare does not pay for a medical visit at the time of an elective procedure. ASC physicians may be seeing patients in their offices and billing separately on post-surgery days.

Table 17
Medicare outpatient payments per specialty hospital for medical^a services, 2004

Hospital type	All claims	ASC-eligible claims		
	Medical payments ^d	Average medical share of all outpatient payments (%) ^b	Medical payments	Average medical share of ASC eligible payments (%) ^c
Cardiac	\$131,125	3.8%	\$7,605	9.4%
Orthopedic	2,824	0.2	406	0.05
Surgical	5,516	0.3	1,032	0.13

NOTES: Only includes claims where Medicare is the primary payor

^aCPT codes in 99,000 series.

^bColumn (1) divided by column (1) in Table 10.

^cColumn (3) divided by column (2) in Table 10.

^dIncludes both ASC-eligible and non-ASC-eligible claims.

SOURCES: NCH 2004 Version I outpatient claims, ASC Pricer Version V05.1, and RTI Specialty Hospital list. Computer output: dh56aPctbl_tbl1.xls, dh56aPctbl2_all2.xls

Tables 18 and 19 present the five highest revenue medical services for all outpatient claims and separately for ASC-eligible claims. The majority of medical payments for orthopedic hospitals were for the emergency department visits and consultations. Established patient office visits were the most common medical services in surgical specialty hospitals, but the revenues were quite minor (roughly \$5,000 per hospital across several codes). An ASC would not staff an emergency department, so most of the orthopedic specialty hospital's medical payments do not appear on ASC-eligible claims. The highest paid procedures for orthopedic and surgical specialty hospitals on ASC-eligible claims were for office visits and consultations. Medical payments on ASC eligible claims were trivial.

¹⁵ We categorized the following HCPCS and CPT codes as medical services: CPT codes 99201–99499 (Evaluation and Management), CPT codes 99000–99199 (special services, procedures, reports), and CPT codes 99500–99602 (home health procedures and services).

Table 18
Payments for top five outpatient medical services by specialty hospital type, all claims, 2004

Cardiac			Orthopedic			Surgical		
HCPCS	Description	Payment	HCPCS	Description	Payment	HCPCS	Description	Payment
99284	Emergency department visit for the E&M of a patient requiring detailed history, moderate complexity	\$46,394	99283	Emergency department visit for the E&M of a patient requiring expanded problem focused history,	\$830	99213	Office or outpatient visit for E&M of established patient	\$3,643
99283	Emergency department visit for the E&M of a patient requiring expanded problem focused history, moderate complexity	\$25,382	99245	Office consultation for new or established patient that requires a comprehensive history	\$664	99211	Office or other outpatient visit for established patient that may not require the presence of a physician	\$1,047
99214	Office or other outpatient visit for established patient that requires at least two of three components; moderate complexity	\$15,985	99284	Emergency department visit for the E&M of a patient requiring detailed history, moderate complexity	\$443	99212	Office or other outpatient visit for established patient that requires at least two of three components; straightforward decision making	\$385
99285	Emergency department visit for the E&M of a patient that requires a high complexity	\$15,671	99282	Emergency department visit that requires expanded problem focused history, low complexity	\$264	99214	Office or other outpatient visit for established patient that requires at least two of three components; moderate complexity	\$305
99213	Office or outpatient visit for E&M of established patient	\$6,546	99211	Office or other outpatient visit for established patient that may not require the presence of a physician	\$196	99243	Office consultation for a new or established patient that requires detailed history, low complexity	\$204

NOTES:

SOURCE: NCH 2004 Version I outpatient claims, ASC Pricer Version V05.1, and RTI Specialty Hospital list.

Table 19
Payments for top five outpatient medical services by specialty hospital type, ASC-eligible claims, 2004

Cardiac			Orthopedic			Surgical		
HCPCS	Description	Payment	HCPCS	Description	Payment	HCPCS	Description	Payment
99214	Office or other outpatient visit for established patient that requires at least 2 of three components; moderate complexity	\$4,577	99245	Office consultation for new or established patient that requires a comprehensive history, high complexity	\$314	99213	Office or outpatient visit for E&M of established patient	\$921
99213	Office or outpatient visit for evaluation and management of established patient	\$1,045	99244	Office consultation for new or established patient that requires a comprehensive history, moderate complexity	\$30	99214	Office or other outpatient visit for established patient that requires at least two of three components; moderate complexity	\$142
99215	Established patient office or other outpatient visit that requires two of three components; high complexity	\$764	99202	New patient Office or other outpatient visit that requires expanded problem focused history; expanded problem focused exam; and straightforward medical decision making	\$24	99243	Office consultation for new or established patient that requires detailed history; low complexity	\$65
99284	Emergency department visit for the E&M of a patient requiring moderate complexity	\$315	99284	Emergency department visit for the E&M of a patient requiring detailed history, moderate complexity	\$16	99203	New patient office or other outpatient visit that requires detailed history; low complexity	\$46
99291	Critical care, evaluation and management of the critically ill or critically injured; first 30-74 minutes	\$215	99201	New patient office or other outpatient visit that requires problem focused history and straightforward decision making	\$12	99215	Established patient office or other outpatient visit that requires two of three components; high complexity	\$14

NOTES:

SOURCE: NCH 2004 Version I outpatient claims, ASC Pricer Version V05.1, and RTI Specialty Hospital list

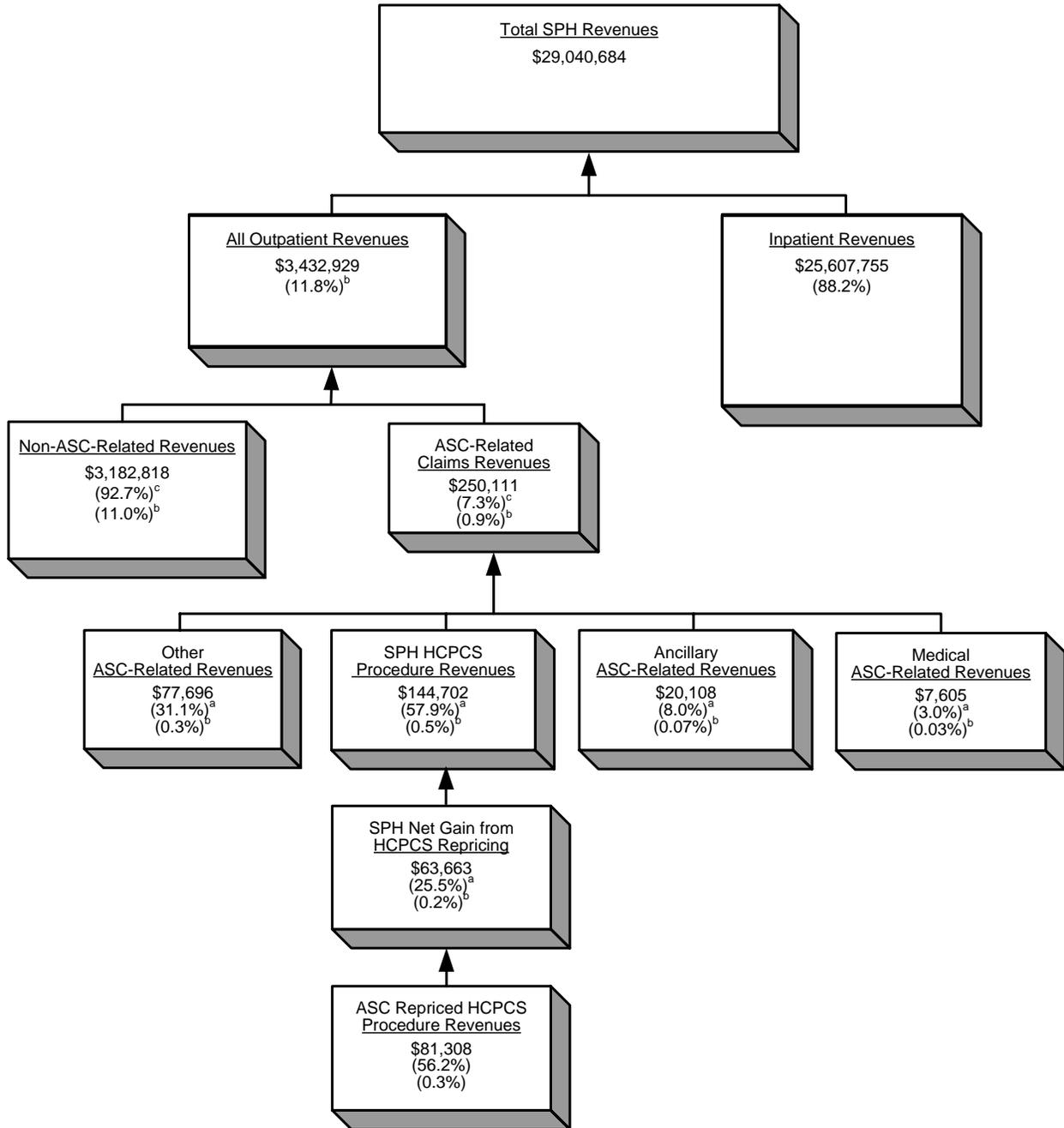
3.6 Decomposition of ASC Repricing Impacts on Specialty Hospital Revenues

Figures 3–5 provide a schematic decomposition showing the impact of ASC repricing on total SPH revenues as well as various components. These diagrams show at a glance the relative size of revenue streams and which incentives might be most important in converting an ASC to an SPH. These figures reproduce numbers shown in previous tables and how they fit together in the total revenue stream. Again, cardiac specialty hospitals (Figure 3) are shown only for illustrative purposes. Beginning at the top of Figure 3, Medicare revenues averaged about \$29 million per cardiac SPH, 88 percent of which is derived from inpatient care. Of all Medicare outpatient payments, non-ASC-eligible revenues comprised over 90 percent. Of the small annual revenue generated from ASC-eligible outpatient claims, nearly 6-tenths (57.9 percent) comes from HCPCS procedure “line item” revenues alone. Another 8 and 3 percent, respectively, comes from extra “broad” ancillary and medical payments associated with the primary procedure. The \$144,702 in average procedure-specific payments can be decomposed into \$81,308 in repriced ASC payments plus a net gain of \$63,663 in additional OPPS payments. This net gain to procedure repricing is two-tenths of 1 percent of cardiac hospital total revenues and one-quarter of the limited revenues derived from ASC-eligible outpatients.

Orthopedic SPHs derive \$1.38 in inpatient Medicare revenues for every \$1.00 in OPPS revenues (58 percent inpatient; 42 percent outpatient; see Figure 4). Of their Medicare outpatient revenues, four-fifths (81.6 percent) is derived from patients who could have been seen at an ASC (i.e., had at least one ASC-covered line item on their hospital claim). Of these ASC-eligible patients, 95 percent of their revenues were from ASC-covered procedures alone. Repriced, these procedures would have been paid roughly 40 percent less in an ASC, or \$761,821. The resulting net hypothetical gain from OPPS pricing arbitrage, about \$485,000 per hospital in 2004, was 13 percent of average total orthopedic SPH Medicare revenues. The other three ASC-eligible revenue streams were trivial. Besides higher OPPS procedure payments, orthopedic SPHs generate an additional 7.7 percent of all their Medicare revenues (\$294,942) from non-ASC-related outpatient claims without an ASC-covered procedure.

Surgical specialty hospitals are far more dependent upon outpatient services than orthopedic SPHs. Nearly three-quarters of their Medicare revenues come from treating patients on an outpatient basis (Figure 5). Of their \$1.9 million in Medicare outpatient payments, almost two-thirds (64.8 percent) comes from ASC-eligible patients and one-third from non-ASC-related visits. ASC-eligible outpatients contribute almost one-half of all Medicare revenues for surgical SPHs (i.e., \$1.2 of \$2.6 million in total). As with orthopedic SPHs, 94 percent of ASC-eligible revenues come from HCPCS procedures covered in an ASC as well. Repriced, these procedures would have been paid 30 percent less (\$804,368) in an ASC, on average. The resulting hypothetical net gain from pricing arbitrage, about \$345,000 per SPH, was 13 percent of average total surgical SPH Medicare revenues. Ancillary and other extra payments associated with ASC-eligible patients were trivial (less than 3 percent of all revenues), especially in comparison with non-ASC-covered outpatient visits (25.3 percent of all revenues).

Figure 3. Decomposition of Cardiac specialty hospital total Medicare revenues per hospital, 2004



NOTES:

^aPercent of all ASC-related claims revenues.

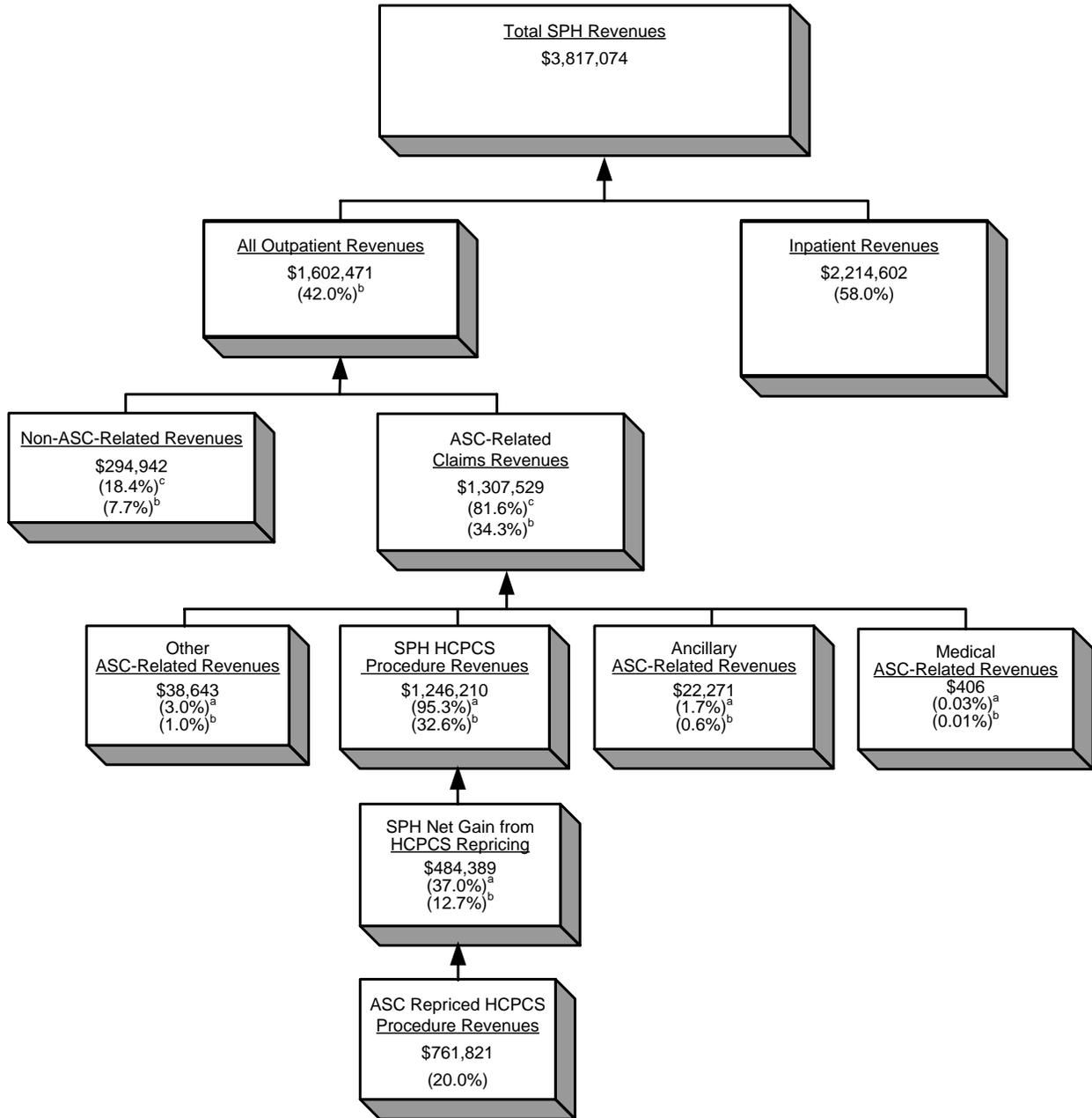
^bPercent of SPH total revenues.

^cPercent of all outpatient revenues.

^dPercent of SPH HCPCS revenues.

SOURCE: NCH 2004 Version I outpatient claims; 2004 Bess.

Figure 4. Decomposition of Orthopedic specialty hospital total Medicare revenues per hospital, 2004



NOTES:

^aPercent of all ASC-related claims revenues.

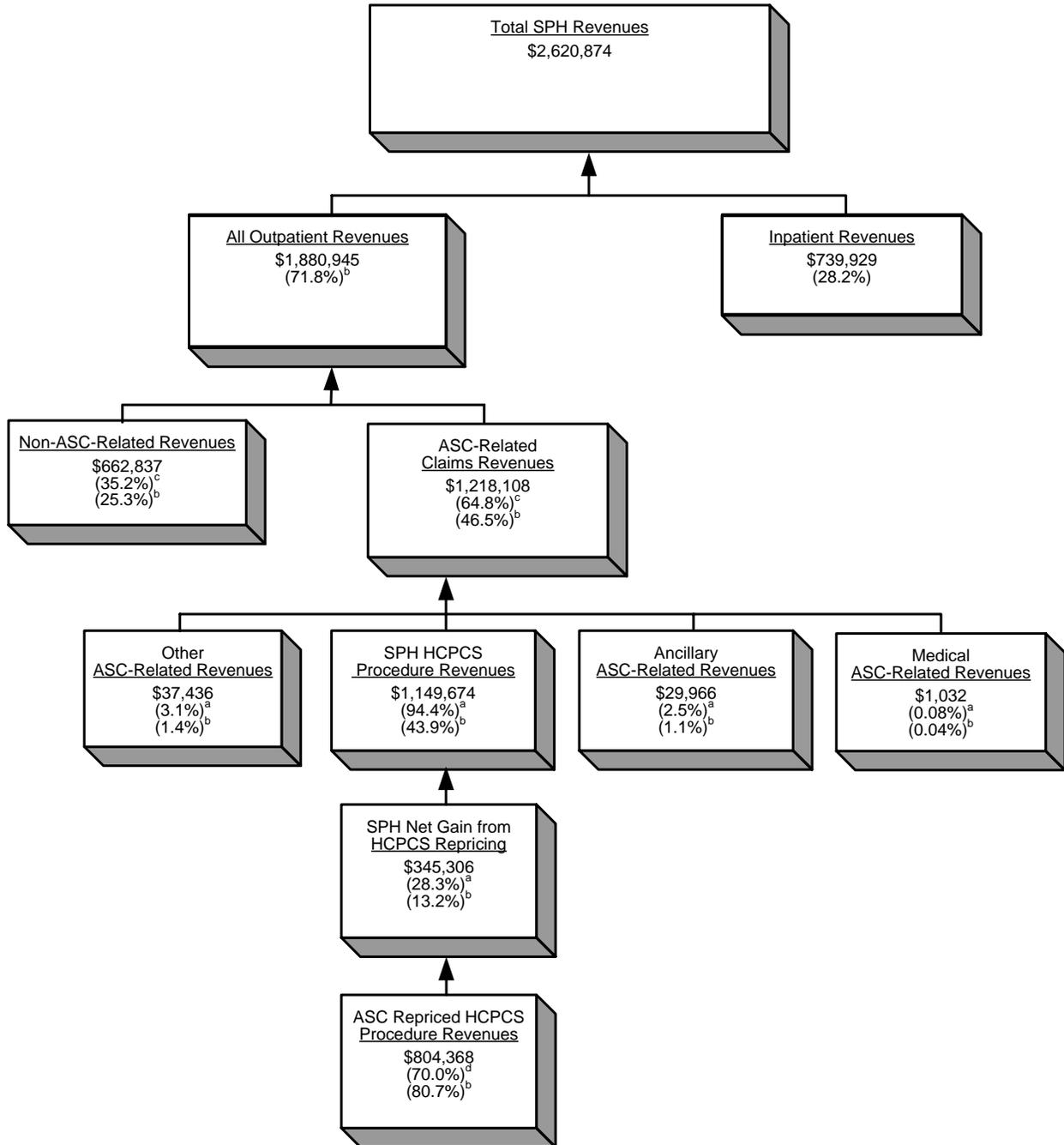
^bPercent of SPH total revenues.

^cPercent of all outpatient revenues.

^dPercent of SPH HCPCS revenues.

SOURCE: NCH 2004 Version I outpatient claims; 2004 Bess.

Figure 5. Decomposition of Surgical specialty hospital total Medicare revenues per hospital, 2004



NOTES:

^aPercent of all ASC-related claims revenues.

^bPercent of SPH total revenues.

^cPercent of all outpatient revenues.

^dPercent of SPH HCPCS revenues.

SOURCE: NCH 2004 Version I outpatient claims; 2004 Bess.

SECTION 4 SUMMARY & CONCLUSIONS

In reviewing the incentives for an ASC to convert to a physician-owned specialty hospital by adding inpatient beds, three additional outpatient revenue sources have been alleged by critics to encourage either the conversion of an ASC to a specialty hospital or physicians investing in one in the first instance:

1. Higher facility outpatient payments for ASC-covered surgical procedures
2. Higher outpatient payments for ancillary and medical services associated with an ASC-eligible procedure
3. Higher outpatient payments for services (especially lab and radiology) not eligible for payment in an ASC

Investors in specialty hospitals, by contrast, have emphasized additional payments for inpatient services as their primary motivation (Cromwell, et al., 2005).

The first revenue stream stems from differences in payment algorithms used by CMS to pay for hospital outpatient versus ASC services for particular surgeries. The former relies on hundreds of Ambulatory Payment Classes (APCs), while the latter bundles procedures into only nine payment categories. Different payment algorithms generate opportunities for payment “arbitrage,” or taking advantage of different payment levels depending on location. The second revenue stream supplements the pure arbitrage advantages to a hospital by paying extra, on occasion, for ancillary and medical services related to the outpatient ASC-eligible surgery. Critics are also concerned that physician owners may be referring patients to their hospital simply for ancillary lab, radiology, and special services that are ineligible for payment in an ASC. Finally, any outpatient revenue gains must be put in perspective by comparing them with the hospital’s total (including inpatient) revenues. That is, how dependent are these facilities on their outpatient services?

Table 19 summarizes the contribution, of each of the major revenue streams that could enhance specialty hospital payments over-and-above payments received by an ASC. Only orthopedic and surgical hospitals are shown because cardiac hospitals perform few ASC-eligible procedures. Revenue gains from outpatient claims with an ASC-related procedure are decomposed into (a) repriced gains from the pricing difference solely for the surgical procedure; (b) “broadly defined” ancillary and other services paid for separately on any ASC-eligible claim, (c) other OPSS ancillary, medical, and special procedure payments on claims without an ASC-procedure, and (d) total inpatient revenues. Note that outpatient lab and radiology payments are included either in lines 4 or 5.

Table 19 summarizes the four revenue sources that distinguish a specialty hospital from an ASC. Orthopedic specialty hospitals averaged \$1.6 million in Medicare outpatient OPSS revenues in 2004. Of this amount, almost four-fifths (\$1.2 million) were from procedures that were also eligible for payment in an ASC. When these procedures are repriced using ASC rates, the gain from OPSS over ASC prices averaged \$484,389, or 64 percent more than under ASC prices. The gain was 30 percent relative to all OPSS revenues and 12.7 percent of all Medicare

revenues. In addition, orthopedic hospitals received an additional \$61,320 in OPPS payments for all other services associated with a procedure, i.e., medical visits, lab and radiology tests. These extra revenues, which are not paid for separately in ASC rates, comprised 3.8 percent of all OPPS revenues.

Table 19
Decomposition of orthopedic and surgical specialty hospital outpatient and inpatient Medicare revenues incorporating ASC repricing, 2004

	Orthopedic (N=43)		Surgical (N=12)	
	Mean \$	Outpatient Percent	Mean \$	Outpatient Percent
Outpatient revenues				
ASC-eligible procedures ^a				
1. Paid under OPPS	\$1,246,210	77.8	\$1,149,674	61.1
2. Repriced under ASC ^b	-761,821		-804,368	
3. Repricing gain	484,359	30.2	345,306	18.3
4. “Ancillary” OPPS payments for ASC-eligible procedures ^c	61,320	3.8	68,434	3.6
5. OPPS payments for services ineligible in an ASC ^d	294,942	18.4	662,837	35.3
6. Total OPPS revenues	1,602,471	100.0	1,880,945	100.0
7. Inpatient revenues	2,214,602		739,929	
8. Total facility revenues	3,817,074		2,620,874	

NOTES: ^aPayments for OPPS line items with ASC-eligible HCPCS codes.

^bPayments for procedure line items using ASC prices.

^cIncludes all HCPCS payments besides payments for the surgical procedure during same visit.

^dPayments for all services not covered in an ASC.

SOURCE: NCH 2004 Version I outpatient claims; 2004 BESS.

Orthopedic specialty hospitals also received \$294,942 in OPSS payments for outpatient visits with no ASC-eligible procedure. Laboratory and radiology services comprised \$163,000 of these additional revenues.¹⁶ Various MRI scans were the top five HCPCS procedures in this non-ASC-eligible category.

Orthopedic specialty hospitals generated an additional \$2.2 million, on average, in Medicare inpatient revenues. When added to outpatient revenues, total Medicare payments averaged \$3.8 million. Every \$1 in Medicare outpatient revenues were associated with \$1.40 in inpatient revenues.

Surgical specialty hospitals average slightly more Medicare outpatient revenues (\$1.9 million) than do orthopedic hospitals, although their total Medicare revenues are approximately 30 percent less when inpatient revenues are also included. For every \$1 in outpatient revenues, these hospitals generated \$0.39 in inpatient revenues. Of total Medicare outpatient revenues, 61 percent come from individual procedures also eligible for payment in ASCs. When repriced using ASC rates, the gain from OPSS over ASC prices for the procedures, alone, is \$345,306. This amounts to a 43 percent increase over ASC-based revenues. The repricing gain was 18.3 percent relative to all OPSS revenues and 13.2 percent of all Medicare revenues. The OPSS-ASC repricing gain is much smaller in percentage terms for surgical than orthopedic hospitals. The primary reason is that surgical specialty hospitals perform a less costly mix of outpatient surgery than do orthopedic hospitals. In addition to the repricing gain, surgical hospitals receive an additional \$68,434, on average, from other services provided during the visit involving an ASC-eligible procedure.

What particularly distinguishes a surgical from an orthopedic specialty hospital outpatient service are the services provided beneficiaries not having any ASC-eligible procedure. These extra Medicare revenues amounted to \$662,837, on average, or over one-third of all of their Medicare outpatient revenues and one-quarter of all their Medicare revenues. Radiology services, alone, accounted for \$313,000 of their non-ASC-eligible outpatient payments. CT and MRI scans were the top five HCPCS revenue generators for patients not undergoing an ASC-eligible procedure.

¹⁶ This figure also includes related payments for ASC-eligible visits as well.

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