

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE BENEFICIARIES
PAID NEARLY HALF OF THE
COSTS FOR OUTPATIENT
SERVICES AT CRITICAL
ACCESS HOSPITALS**



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Inspector General**

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EXECUTIVE SUMMARY: MEDICARE BENEFICIARIES PAID NEARLY HALF OF THE COSTS FOR OUTPATIENT SERVICES AT CRITICAL ACCESS HOSPITALS OEI-05-12-00085

WHY WE DID THIS STUDY

The Critical Access Hospital (CAH) certification was created to ensure that rural beneficiaries would have access to hospital services. Medicare reimburses CAHs at 101 percent of their “reasonable costs,” rather than at the predetermined rates set by the Outpatient Prospective Payment System (OPPS).

The system that Medicare uses to calculate outpatient coinsurance amounts for beneficiaries who receive services at CAHs differs from that used for beneficiaries who receive services at acute-care hospitals. Beneficiaries who receive services at CAHs pay coinsurance amounts based on CAH charges, whereas beneficiaries who receive services at acute-care hospitals pay coinsurance amounts based on OPPS rates. CAH charges are typically higher than the reasonable costs associated with CAH services or the OPPS rates that acute-care hospitals receive.

HOW WE DID THIS STUDY

We used 2009 and 2012 claims data to calculate the percentages and amounts of coinsurance that Medicare beneficiaries paid toward the costs for outpatient services at CAHs. Additionally, we calculated the percentages and amounts of coinsurance that beneficiaries would have paid at acute-care hospitals for 10 outpatient services that were frequently provided at CAHs.

WHAT WE FOUND

Because coinsurance amounts were based on charges, Medicare beneficiaries paid nearly half the costs for outpatient services at CAHs. In 2012, beneficiaries paid approximately \$1.5 billion of the estimated \$3.2 billion cost for CAH outpatient services. Additionally, the average percentage of costs that beneficiaries paid in coinsurance for these services increased 2 percentage points between 2009 and 2012. Finally, for 10 outpatient services that were frequently provided at CAHs, beneficiaries paid between 2 and 6 times the amount in coinsurance than they would have for the same services at acute-care hospitals.

WHAT WE RECOMMEND

Because coinsurance amounts were based on charges, Medicare beneficiaries paid a higher percentage of the costs in coinsurance for outpatient services received at CAHs than they would have paid at hospitals under OPPS. Further, the percentage of costs that Medicare beneficiaries paid in coinsurance for outpatient services at CAHs has increased in recent years. To reduce the percentage of costs that Medicare beneficiaries pay in coinsurance, we recommend that CMS seek legislative authority to modify how coinsurance is calculated for outpatient services received at CAHs. Some ways in which CMS could modify how coinsurance is calculated for such services include (1) computing coinsurance so that it is based on interim payment rates rather than charges and (2) processing claims for outpatient services at CAHs as if they were paid under OPPS for the purpose of calculating an OPPS-equivalent coinsurance. CMS responded to the report but neither concurred nor nonconcurred with our recommendation.

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OBJECTIVES

To determine:

1. what percentage of costs beneficiaries paid in coinsurance for outpatient services at Critical Access Hospitals (CAHs),
2. how the percentage of costs that beneficiaries paid in coinsurance for outpatient services at CAHs changed over time, and
3. how the coinsurance that beneficiaries paid for outpatient services at CAHs compared to the coinsurance that they would have paid for outpatient services at acute-care hospitals.

BACKGROUND

Critical Access Hospitals

The Balanced Budget Act (BBA) of 1997 created the CAH certification to ensure that hospital care would be accessible to beneficiaries in rural communities.^{1,2} Small hospitals that meet specific requirements can qualify for the CAH certification and receive favorable Medicare reimbursements.

There are more than 1,300 CAHs in the United States. CAHs are located in each of the 50 States except Connecticut, Delaware, Maryland, New Jersey, and Rhode Island. CAHs provided outpatient services to approximately 2.4 million beneficiaries in 2012. Medicare and beneficiaries paid approximately \$4.3 billion for these services.

Medicare Payments to CAHs and Acute-Care Hospitals

Medicare pays CAHs under a system different from that for paying most other hospitals. CAHs receive 101 percent of their “reasonable costs” for outpatient services provided.^{3,4} Medicare determines these costs using information from CAHs’ cost reports, on which hospitals report their costs and charges for services provided.⁵ In contrast, Medicare pays for outpatient services at most

¹ BBA, P.L. No. 105-33 § 4201. The BBA amended several sections of the Social Security Act, including sections 1814(l), 1820, 1834(g), and 1861(mm).

² Centers for Medicare & Medicaid Services (CMS), *State Operations Manual*, Pub. No. 100-07, ch. 2, § 2254A. Accessed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS1201984.html> on April 4, 2014.

³ Social Security Act, § 1834(g), 42 U.S.C. § 1395m(g).

⁴ “Reasonable costs” are the direct and indirect costs associated with providing services to Medicare beneficiaries. 42 CFR § 413.9(b)(1).

⁵ 42 CFR § 413.20(a). “Costs” refer to the costs of providing services, including the costs of staff, buildings, and equipment. “Charges” refer to the amounts charged by the hospitals for those services.

acute-care hospitals using the outpatient prospective payment system (OPPS), which pays predetermined rates for outpatient services.⁶

During the year, Medicare pays CAHs interim payments for services provided. Medicare calculates these interim payments using the previous year's costs of covered services along with any adjustments it deems necessary.⁷ Medicare intends these interim payments to reflect actual costs as closely as possible.

After CAHs file their cost reports, Medicare determines the final costs and makes additional payment adjustments.⁸ For example, if the total of (1) the interim payments that a CAH received from Medicare and (2) the coinsurance CAHs received from beneficiaries is less than 101 percent of the costs of those services, Medicare would make an additional payment to the CAH. However, if the interim payments that a CAH received *exceed* 101 percent of the costs of those services, Medicare will notify the CAH that it will reduce or suspend the CAH's interim payments unless the CAH makes repayment arrangements.⁹

For both CAHs and acute-care hospitals, Medicare deducts beneficiary payments (including coinsurance) from the costs of the services and from the OPPS rates, respectively, to determine the amounts it should pay for outpatient services.¹⁰

Beneficiary Coinsurance Payments to CAHs and Acute-Care Hospitals

Although Medicare beneficiaries are responsible for paying coinsurance for most outpatient services regardless of where they are received, the system that Medicare uses to compute coinsurance amounts for services received at CAHs differs from that used for beneficiaries at acute-care hospitals. Beneficiaries who receive outpatient services at CAHs pay 20 percent of the charges submitted by CAHs for those services, as mandated by law.¹¹

⁶ Social Security Act, § 1833(t), 42 U.S.C. § 1395l(t).

⁷ 42 CFR § 413.64(e).

⁸ 42 CFR § 413.64(f).

⁹ CMS, *Medicare Financial Management Manual*, Pub. No. 100-006, ch. 3, § 20.1. Accessed at <http://cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019018.html?DLPage=1&DLSort=0&DLSortDir=ascending> on April 17, 2014.

¹⁰ Social Security Act, § 1833(a), 42 U.S.C. § 1395l(a).

¹¹ Social Security Act, § 1866(a)(2)(A), 42 U.S.C. § 1395cc(a)(2)(A).

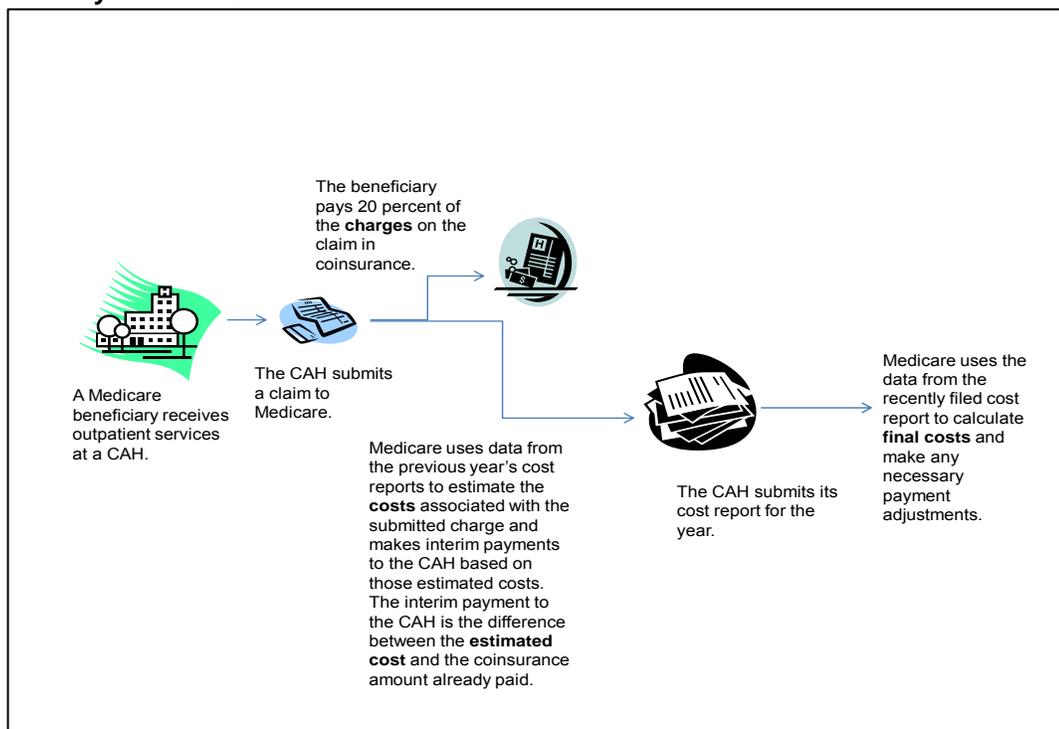
In contrast, beneficiaries who receive outpatient services at acute-care hospitals pay coinsurance amounts that are a percentage of the OPPS-specified hospital payment rates.¹²

In 2012, the Medicare Payment Advisory Commission (MedPAC) found that the average rate of coinsurance paid for outpatient services at acute-care hospitals was 22 percent of the OPPS rates.¹³

Not all types of outpatient services require Medicare beneficiaries to pay coinsurance.¹⁴ Beneficiaries generally do not pay coinsurance for laboratory services or for certain preventive services.

Figure 1 illustrates how Medicare payments and beneficiary coinsurance payments to CAHs are calculated. Figure 2 illustrates how Medicare payments and beneficiary coinsurance payments to acute-care hospitals are calculated.

Figure 1: Calculation of Medicare Payments and Beneficiary Coinsurance Payments to CAHs



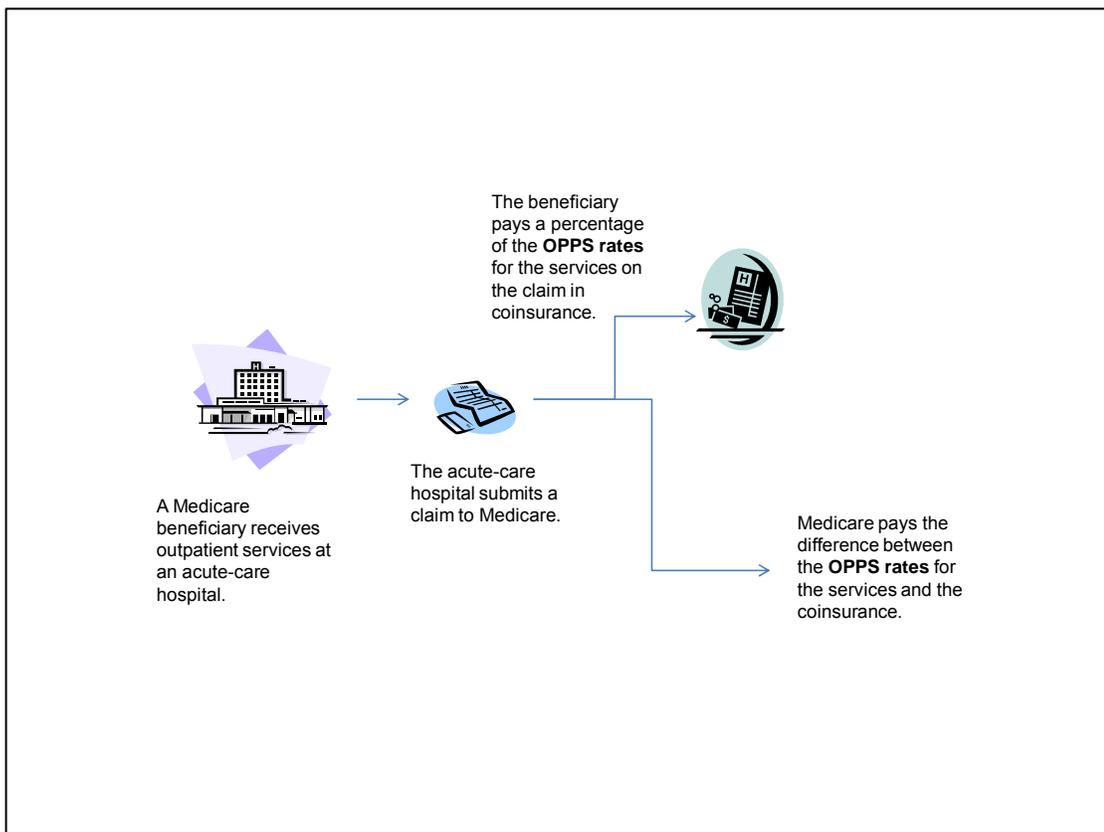
Source: OIG analysis of Medicare payment policies for outpatient services at CAHs, 2014.

¹² Social Security Act, § 1833(t)(3)(B), 42 U.S.C § 1395l(t)(3)(B).

¹³ MedPAC, *Payment Basics: Outpatient Hospital Services Payment System* (revised October 2013).

¹⁴ Social Security Act, § 1866(a)(2)(A), 42 U.S.C. § 1395cc(a)(2)(A). Social Security Act, § 1833(a)(1), 42 U.S.C. § 1395l(a)(1).

Figure 2: Calculation of Medicare Payments and Beneficiary Coinsurance Payments to Acute-Care Hospitals



Source: OIG analysis of Medicare payment policies for outpatient services at acute-care hospitals, 2014.

Coinsurance for Medicare beneficiaries who receive outpatient services at acute-care hospitals has not always been determined as a percentage of OPSS. Prior to the creation of OPSS in 2000, coinsurance for outpatient services at acute-care hospitals was based on charges and had reached almost 50 percent of the total Medicare payments for those services. Under OPSS, coinsurance declines each year until it reaches 20 percent of the predetermined OPSS rates.¹⁵

¹⁵ 65 Fed. Reg. 18434, 18487 (Apr. 7, 2000). For each service, an unadjusted coinsurance amount was calculated by taking 20 percent of the national median charges billed in 1996, trended forward to 1999. The unadjusted coinsurance amount can never be less than 20 percent of the OPSS payment rate. The unadjusted coinsurance amount remains frozen until it equals 20 percent of the OPSS rate for the service, and then it will be updated annually to remain equal to 20 percent of the OPSS rate. Because the unadjusted coinsurance amounts were calculated from national median charges, in the early years of OPSS they remained a high percentage of the total Medicare payments.

Related Work

OIG has a body of work that examines CAH locations and services. In 2013, OIG found that nearly two-thirds of CAHs were located near other hospitals.¹⁶ OIG also found that Medicare and beneficiaries could realize substantial savings if CMS decertified some of these CAHs and recertified them as acute-care hospitals. OIG also found in 2013 that Medicare beneficiaries who receive services at CAHs primarily received outpatient services.¹⁷ Finally, OIG is conducting a nationwide review of “swing bed” services at CAHs.¹⁸

In 2011, MedPAC released a report that examined coinsurance payments at CAHs in 2008 and 2009.¹⁹ In the report, MedPAC proposed several possible modifications to the method used to calculate coinsurance at CAHs.

METHODOLOGY

Scope

We reviewed outpatient claim files to identify the percentage of costs that Medicare beneficiaries paid in coinsurance for outpatient services received at CAHs in 2009 and in 2012.

We excluded services for which beneficiaries paid part or all of their deductibles, as the deductible amounts may have reduced the amount of coinsurance paid.²⁰ We also excluded services for which beneficiaries are not required to pay coinsurance (e.g. laboratory services). Finally, we excluded services that were not paid for under traditional Medicare (e.g., services paid under managed care), professional services performed at CAHs, and services for which Medicare did not pay. Because of these exclusions, we reviewed outpatient services for approximately 1.7 million beneficiaries. For a breakdown of the number of services included and excluded from our analysis, see Appendix A.

¹⁶ OIG, *Most Critical Access Hospitals Would Not Meet the Location Requirements If Required To Re-Enroll in Medicare*, OEI-05-12-00080, August 2013.

¹⁷ OIG, *Services Provided at Critical Access Hospitals in 2011*, OEI-05-12-00081, December 2013.

¹⁸ A “swing bed” is a bed that is reimbursed for skilled nursing services.

¹⁹ MedPAC, *Medicare Copayments for Critical Access Hospital Outpatient Services—2009 Update*, December 2011.

²⁰ A deductible is the amount that a beneficiary must pay out of pocket before Medicare will pay for any expenses. In 2012, the deductible for Medicare Part B services (which includes outpatient services) was \$140. 76 Fed. Reg. 67572, 67574 (Nov. 1, 2011).

Data Sources and Analysis

We used CMS's 2009 and 2012 National Claims History (NCH) outpatient claim files to calculate the average percentages of costs that Medicare beneficiaries paid in coinsurance toward the costs of outpatient services received at CAHs. We also used the Minimum Unadjusted Copayment amount published in CMS's 2012 January Web Addendum B Outpatient Prospective Payment file to approximate the amounts that beneficiaries would have paid in coinsurance at acute-care hospitals for 10 outpatient services that were frequently provided at CAHs.²¹

For a detailed discussion of our data sources and analysis, see Appendix A.

Limitations

We used outpatient claims as a proxy for Medicare costs for outpatient services at CAHs. The amounts reported on the claims represent interim payments. Medicare uses data from the previous year's cost reports along with any other necessary adjustments to estimate its interim payments, which are intended to reflect the current cost of services. Because of Medicare's process for estimating payments, we believe that the estimated payment amounts reported in the claims are reasonable approximations of the final costs of outpatient services. However, because final reimbursements for services provided at CAHs are computed retrospectively, the actual final costs could be higher or lower.

Standards

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

²¹ The Minimum Unadjusted Copayment is the lowest amount of coinsurance that an acute-care hospital can charge for a service. It is equal to 20 percent of the service's rate. 66 Fed. Reg. 44672, 44696-97 (Aug. 24, 2001).

FINDINGS

Because coinsurance amounts were based on charges, Medicare beneficiaries paid nearly half the costs for outpatient services at CAHs

Of the estimated \$3.2 billion CAHs received for outpatient services provided in 2012, approximately \$1.5 billion resulted from Medicare beneficiaries' coinsurance payments (47 percent). Approximately 681,000 beneficiaries who received outpatient services at CAHs paid an average of more than half of the costs in coinsurance, including 146,000 who paid more than 75 percent of the costs in coinsurance. Table 1 shows the distribution of the average percentage of costs in coinsurance paid to CAHs in 2012.

Table 1: Distribution of the Average Percentage of Costs That Beneficiaries Paid (as Coinsurance) to CAHs in 2012

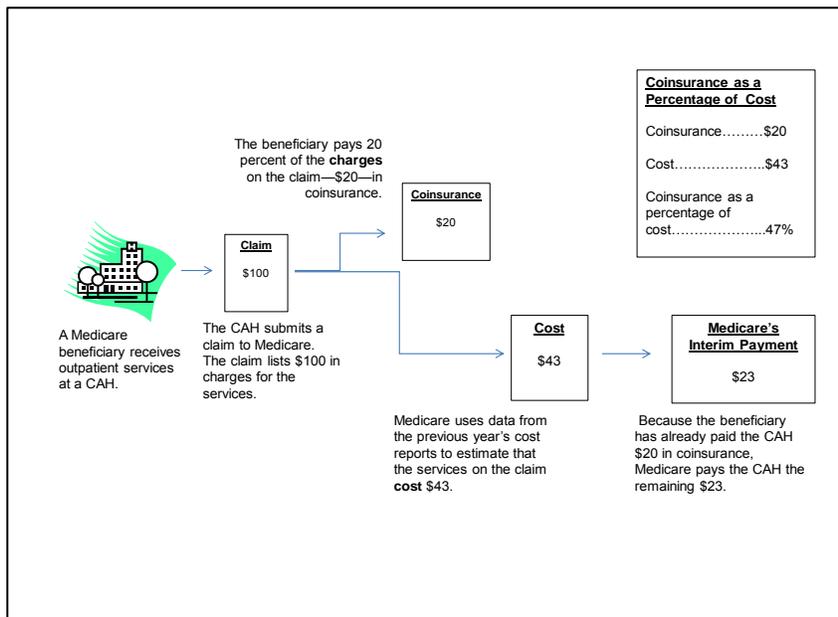
Average percentage of costs	Number of beneficiaries	Percentage of beneficiaries*
>75%	146,480	8%
>50% and ≤75%	534,795	31%
>25% and ≤50%	1,011,344	58%
≤25%	40,969	2%
Total	1,733,588	100%

Source: OIG analysis of NCH Outpatient Files, 2012.

* This column does not sum to 100 percent because of rounding.

Beneficiaries paid an average of 47 percent of the costs for outpatient services at CAHs in coinsurance because *charges*—the basis for CAH coinsurance payments—are typically greater than the *costs* of the services. A 2011 MedPAC report found that CAHs' average charges for outpatient services were more than double the average costs of the services. This can happen because charges are not required to be tied to costs in any way; CAHs are allowed to set their charges at any rate. Because charges are higher than costs, the amount of coinsurance calculated from charges can constitute a significant proportion of the cost. Figure 3 shows how coinsurance calculated from charges results in coinsurance payments that constitute a high percentage of the costs of the service.

Figure 3: How Coinsurance Calculated From Charges Results in Coinsurance Payments That Are a High Percentage of Costs



Source: OIG analysis of Medicare payment policies for outpatient services at CAHs, 2014.

The average percentage of costs that Medicare beneficiaries paid in coinsurance for outpatient services at CAHs increased slightly from 2009 to 2012

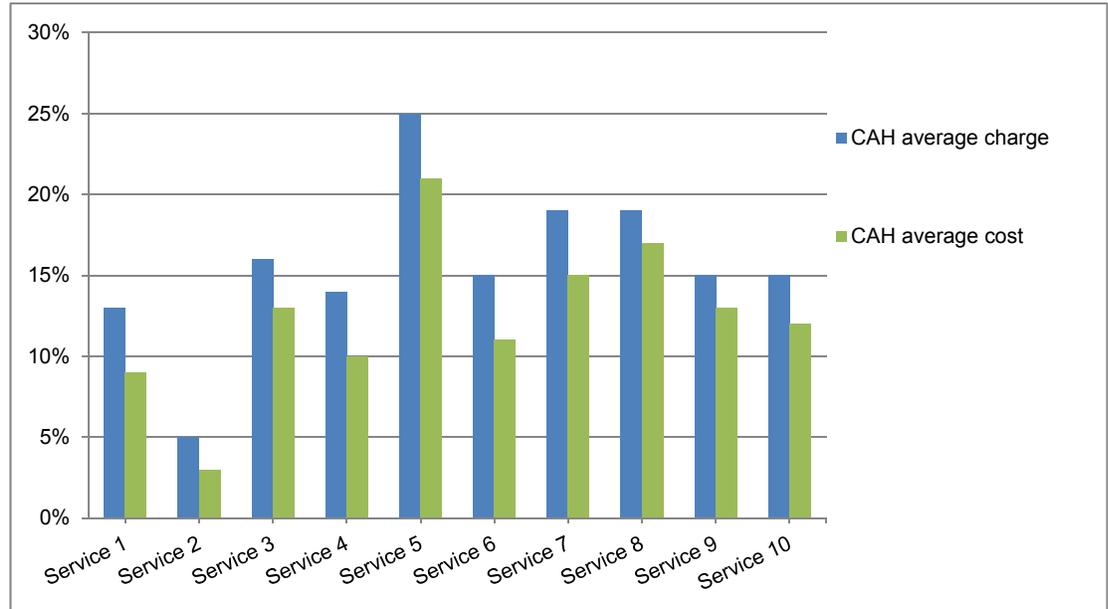
The average percentage of costs that Medicare beneficiaries paid in coinsurance for outpatient services at CAHs increased from 45 percent in 2009 to 47 percent in 2012.

The average percentage of costs that beneficiaries paid in coinsurance for outpatient services at CAHs increased because charges for outpatient services at CAHs typically increased faster than costs. Because coinsurance is based on charges, when charges increase, coinsurance also increases. Thus, charges that increase faster than costs result in coinsurance amounts that make up increasingly larger percentages of costs.

CAH charges increased faster than costs from 2009 to 2012 for outpatient services frequently provided at CAHs. The average charges for these services increased between 2 and 5 percentage points more than the average costs for these services. For example, between 2009 and 2012, CAHs' average charges for electrocardiogram tracing increased 4 percentage points more than the average costs; average *charges* increased by 13 percent, while average *costs* increased by 9 percent. Chart 1 illustrates the percentage increase in charges and costs for outpatient services frequently provided at CAHs.

See Appendix B for coinsurance amounts, costs, and charges for outpatient services frequently provided at CAHs in 2009 and 2012.

Chart 1: Percentage Increase in Charges and Costs for Outpatient Services Frequently Provided at CAHs in 2009 and 2012



Source: OIG analysis of 2009 and 2012 National Claims History (NCH) outpatient files, 2014. For descriptions of these 10 services, see Table 5 on page 18.

The percentage of beneficiaries who paid (as coinsurance) an average of more than 50 percent of the costs for outpatient services at CAHs has increased by 9 percentage points

In 2009, 30 percent of Medicare beneficiaries (approximately 521,000) paid an average of more than half of the costs for outpatient services at CAHs in coinsurance. In 2012, the figure was 39 percent (nearly 700,000 beneficiaries).

Because coinsurance amounts were based on charges, Medicare beneficiaries paid more in coinsurance for outpatient services at CAHs than they would have paid at acute-care hospitals

Medicare beneficiaries who received outpatient services at CAHs typically paid more in coinsurance—both in absolute amounts and in percentage of costs—than they would have for the same services at acute-care hospitals.

For the 10 frequently provided outpatient services, beneficiaries' average coinsurance amounts at CAHs were between 2 and 6 times the coinsurance amounts for the same services provided at acute-care hospitals. In the case of electrocardiogram tracing—the most frequently provided service included in this analysis—beneficiaries who received the service at CAHs paid an average coinsurance amount that was more than the entire OPPS rate for the service. The differences in the coinsurance amounts were a result of CAHs' average charges for these services being more than double the OPPS rate for the same services. Table 2 presents beneficiaries' coinsurance amounts at CAHs and acute-care hospitals for outpatient services frequently provided at CAHs in 2012.

Table 2: Beneficiaries' Coinsurance Amounts at CAHs and Acute-Care Hospitals in 2012 for Frequently Provided Outpatient Services

Service number	Service type	Number of times service was provided at CAHs	Basis for calculating coinsurance		Coinsurance payments*	
			CAHs' average charge	OPPS payment rate at acute-care hospital	Beneficiary average coinsurance amount at CAHs	Beneficiary minimum unadjusted copayment amount at acute-care hospitals**
Service 1	Electrocardiogram tracing	759,686	\$164.31	\$26.75	\$32.86	\$5.35
Service 2	Hydrate IV infusion add-on	655,763	\$89.66	\$24.81	\$17.93	\$4.96
Service 3	Therapeutic, prophylactic, or diagnostic injection; subcutaneous or intramuscular	442,458	\$70.12	\$34.81	\$14.03	\$6.96
Service 4	Therapeutic, prophylactic, or diagnostic injection; IV push, new drug add-on	338,707	\$110.45	\$34.81	\$22.09	\$6.96
Service 5	Intravenous infusion (initial)	297,692	\$277.77	\$126.64	\$55.55	\$25.33
Service 6	Therapeutic, prophylactic, or diagnostic injection; IV push	288,644	\$131.31	\$34.81	\$26.26	\$6.96
Service 7	Cardiac rehab/monitor	238,445	\$171.15	\$69.61	\$34.23	\$13.92
Service 8	Airway inhalation treatment	186,575	\$84.80	\$29.71	\$16.96	\$7.72
Service 9	Intravenous infusion (additional)	180,779	\$99.98	\$34.81	\$20.00	\$6.96
Service 10	Transthoracic echocardiogram with Doppler complete	89,674	\$1,540.40	\$392.78	\$308.08	\$78.56

Source: OIG analysis of 2012 NCH outpatient files, 2014.

* The columns below compare average CAH coinsurance payments to minimum copayment amounts. The coinsurance amounts, which are presented in dollars, represent a percentage of the average charges for the services, while the copayment amounts are the minimum flat amounts that Medicare beneficiaries are required to pay at acute-care hospitals. Beneficiaries pay the minimum copayment amount only when 20 percent of the cost of the service is less than the minimum copayment value.

** CMS 2012 January Web Addendum B file. Coinsurance amounts are adjusted for geographic location and the complexity of the services provided.

Previous OIG work found similar results. In a report published in 2013, OIG found that Medicare beneficiaries paid an average of \$400 more in coinsurance for outpatient services received at some CAHs in 2011 than they

would have if those CAHs were recertified as acute-care hospitals and paid under OPPS.²²

Finally, Medicare beneficiaries typically paid a greater percentage of the costs in coinsurance for outpatient services received at CAHs than they would have for the same services at acute-care hospitals. As previously stated, beneficiaries paid an average of 47 percent of costs for outpatient services at CAHs in 2012. In contrast, MedPAC found that beneficiaries' coinsurance payments for outpatient services at acute-care hospitals paid under OPPS accounted for 22 percent of the OPPS rates in that same year.

²² OIG, Most Critical Access Hospitals Would Not Meet the Location Requirements If Required To Re-Enroll in Medicare, OEI-05-12-00080, August 2013.

CONCLUSION AND RECOMMENDATION

Because coinsurance amounts were based on charges, Medicare beneficiaries paid a higher average percentage of the costs in coinsurance for outpatient services received at CAHs than they would have paid at hospitals under OPSS. Beneficiaries paid an average of 47 percent of the costs for outpatient services received at CAHs, compared to an average of 22 percent of the OPSS rates for outpatient services received at acute-care hospitals in 2012.

Further, the percentage of costs that Medicare beneficiaries paid in coinsurance for outpatient services at CAHs increased from 45 percent in 2009 to 47 percent in 2012, as charges have typically increased faster than costs.

Also because coinsurance amounts were based on charges, beneficiaries paid more in coinsurance for outpatient services provided at CAHs than they would have paid at acute-care hospitals. For the 10 outpatient services most frequently provided at CAHs, CAH beneficiaries paid coinsurance amounts that were 2 to 6 times the OPSS coinsurance rates. For one of these services, the average coinsurance amount that CAH beneficiaries paid was more than the total OPSS rate.

With the creation of OPSS, CMS has successfully addressed concerns about coinsurance amounts that were a large percentage of the costs of outpatient services at acute-care hospitals. Prior to OPSS, Medicare beneficiaries who received outpatient services at acute-care hospitals were paying 50 percent of the costs for those services in coinsurance. CMS implemented OPSS, in part, to bring beneficiaries' coinsurance amounts down to 20 percent of the Medicare reimbursements for outpatient services at acute-care hospitals. To achieve a similar change for beneficiaries receiving outpatient services at CAHs, we recommend that CMS:

Seek legislative authority to modify how coinsurance is calculated for outpatient services received at CAHs

CMS should draft, and submit to HHS for review, a legislative proposal that would modify how coinsurance is calculated for outpatient services at CAHs. Because the method for calculating coinsurance for outpatient services at CAHs is mandated by law, any change would require legislative authority. CMS could include in the proposal one of several modifications that would change the method for calculating coinsurance from a figure based on charges to a figure that more closely represents costs.

Several possible modifications that CMS could use can be found in a 2011 report by MedPAC. Medicare could apply to coinsurance calculations the same process currently used to estimate CAHs' interim payments, so that coinsurance amounts would be based on interim payments rather than on

charges. Alternatively, Medicare could process outpatient claims at CAHs as though they were being paid for under OPSS and charge beneficiaries the OPSS coinsurance rates.

Implementing this recommendation would result in increased Medicare payments to CAHs for outpatient services. Medicare pays the difference between the costs of the services and the amount beneficiaries pay in coinsurances and deductibles. Therefore, if beneficiary payments were to decrease, Medicare payments would increase.

If CMS wanted to take steps to mitigate the potential increase in Medicare expenditures, it could do so in multiple ways, seeking legislative changes as needed. As it did with OPSS, it could phase in the changes over several years to reduce the immediate burden to Medicare. It could also offset the potential increase in Medicare expenditures by ensuring that only those CAHs that meet all participation requirements continue to receive cost-based reimbursements. In 2013, OIG found that most CAHs would not meet the location requirements if required to re-enroll in Medicare because a significant number of these CAHs were located near hospitals or other CAHs. In response to the 2013 report, CMS agreed to periodically reassess CAHs' compliance with all location-related participation requirements.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS responded to the report but neither concurred nor nonconcurred with our recommendation.

We continue to encourage CMS to seek legislative authority to modify how coinsurance is calculated for outpatient services received at CAHs. Because coinsurance for outpatient services is calculated from submitted charges rather than from final costs, beneficiaries who receive outpatient services at CAHs typically pay more—in terms of both the percentage of final costs and total amounts—than beneficiaries who receive outpatient services from hospitals paid under OPPS.

Prior to the creation of OPPS, all beneficiaries paid high percentages of the final costs for outpatient services. OPPS reduced coinsurance for outpatient services to 20 percent of the final costs for beneficiaries who received services at hospitals paid under OPPS. A similar change should be made to the way coinsurance is calculated for services at CAHs so that CAH beneficiaries are not subject to coinsurance amounts that are almost 50 percent of the costs. We will routinely follow up with CMS about implementing this recommendation.

For the full text of CMS's comments, see Appendix C.

APPENDIX A

Detailed Methodology

Data Sources

2009 and 2012 NCH outpatient files. The NCH outpatient files contain the outpatient claims data submitted by CAHs for Medicare reimbursement.

We excluded certain claim lines from our analysis if any of the following were applicable: the beneficiary paid a deductible, the beneficiary did not pay coinsurance, traditional Medicare was not the payer, the claim lines represented professional services, or Medicare did not pay for the service on the claim line. Table 4 shows the number of claim lines that we eliminated from our analysis for each of these reasons in 2009 and 2012.

Table 4: Number of Claim Lines Excluded From Analysis

	2009	2012
Total claim lines	53,307,846	58,992,752
Claim lines for which beneficiaries paid a deductible	1,516,232	1,700,278
Claim lines for which beneficiaries did not pay coinsurance*	28,176,500	31,243,246
Claim lines for which traditional Medicare was not the payer	0	1,797
Claim lines that represented professional services	2,565,891	2,971,289
Claim lines for which Medicare did not pay	1	35
Total claim lines used in analysis	21,049,222	23,076,107

Source: OIG analysis of 2009 and 2012 NCH outpatient files, 2014.

* For both 2009 and 2012, more than 90 percent of the claim lines for which beneficiaries did not pay coinsurance were laboratory services.

2012 January Web Addendum B Outpatient Prospective Payment file. CMS's 2012 January Web Addendum B outpatient prospective payment file contains status indicators, costs, and coinsurance amounts for all outpatient services.

Data Analysis

Average percentage of costs paid in coinsurance. We used the NCH outpatient files to calculate the percentage of the costs that beneficiaries paid in coinsurance for outpatient services received at CAHs in 2009 and 2012. We divided the total coinsurance amount by the total coinsurance amount plus the total Medicare payment amount for each service to determine the percentage of the estimated costs for outpatient services at CAHs that was paid as coinsurance. We then calculated the average percentage of costs in coinsurance that beneficiaries paid to CAHs in each year.

Frequently provided outpatient services at CAHs. We used the NCH outpatient files to identify frequently provided outpatient services at CAHs in 2012. We used the 2012 January Addendum B file to identify outpatient services categorized as significant procedures. We selected the 10 most frequently provided significant procedures to include in our analysis.²³ We then excluded any services that were billed with a modifier to ensure that we were comparing similar services between CAHs and acute-care hospitals.²⁴

We calculated the average charges, costs, and coinsurance amounts for these frequently provided outpatient services. To determine the average charge for each service, we summed the charges and divided by the number of times the service was provided. To determine the average cost for each service, we added the coinsurance amounts plus the Medicare payment amounts and divided by the number of times the service was performed. To determine the average coinsurance amount for each service, we summed the coinsurance amounts for each service and divided by the number of times the service was provided.

We also analyzed 2009 NCH outpatient data as described above to calculate the average charges, costs, and coinsurance amounts for the same set of 10 outpatient services frequently provided at CAHs. We identified these 10 services using the 2012 outpatient data.

²³ Significant procedures were identified by selecting services associated with status indicator codes S (Significant Procedure, Not Discounted when Multiple) and T (Significant Procedure, Multiple Reduction Applies).

²⁴ Modifiers are used to provide additional details about the services provided. Some modifiers affect payments.

APPENDIX B

Charges, Coinsurance Amounts, and Costs for Outpatient Services Frequently Provided at CAHs in 2009 and 2012

Table 5: Charges, Coinsurance Amounts, and Costs for Outpatient Services Frequently Provided at CAHs in 2009 and 2012

Service number	Services	CAH average charge		Percent change	Beneficiary average coinsurance amount at CAHs		Percent change	CAH average cost		Percent change
		2009	2012		2009	2012		2009	2012	
Service 1	Electrocardiogram tracing	\$144.80	\$164.31	13%	\$28.96	\$32.86	13%	\$62.71	\$68.24	9%
Service 2	Hydrate IV infusion add-on	\$85.76	\$89.66	5%	\$17.15	\$17.93	5%	\$35.93	\$36.84	3%
Service 3	Therapeutic, prophylactic, or diagnostic injection; subcutaneous or intramuscular	\$60.54	\$70.12	18%	\$12.11	\$14.03	18%	\$27.11	\$30.55	15%
Service 4	Therapeutic, prophylactic, or diagnostic injection; IV push, new drug add-on	\$96.87	\$110.45	14%	\$19.37	\$22.09	14%	\$40.34	\$44.24	9%
Service 5	Intravenous infusion (initial)	\$221.91	\$277.77	25%	\$44.38	\$55.55	25%	\$98.37	\$119.22	21%
Service 6	Therapeutic, prophylactic, or diagnostic injection; IV push	\$114.26	\$131.31	14%	\$22.85	\$26.26	14%	\$49.11	\$54.42	10%
Service 7	Cardiac rehab/monitor	\$144.05	\$171.15	19%	\$28.81	\$34.23	18%	\$66.70	\$76.50	15%
Service 8	Airway inhalation treatment	\$71.44	\$84.80	19%	\$14.29	\$16.96	19%	\$29.93	\$34.86	17%
Service 9	Intravenous infusion (additional)	\$86.92	\$99.98	15%	\$17.38	\$20.00	15%	\$38.17	\$43.05	13%
Service 10	Transthoracic echocardiogram with Doppler complete	\$1,337.43	\$1,540.40	15%	\$267.49	\$308.08	15%	\$578.72	\$648.79	12%

Source: OIG analysis of 2009 and 2012 NCH outpatient files, 2014.

APPENDIX C

Agency Comments



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: AUG 29 2014

TO: Daniel R. Levinson
Inspector General

FROM: Marilyn Tavenier */S/*
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: Medicare Beneficiaries Paid Nearly Half of the Costs for Outpatient Services at Critical Access Hospitals (OEI-05-12-00085)

Thank you for the opportunity to review and comment on the above-subject report. OIG's objective was to determine—(1) The percentage of costs beneficiaries paid in coinsurance for outpatient services at Critical Access Hospitals (CAHs); (2) How the percentage of costs beneficiaries paid in coinsurance for outpatient services at CAHs changed over time; and (3) How the coinsurance beneficiaries paid for outpatient services at CAHs compared to the coinsurance beneficiaries would have paid for outpatient services at acute-care hospitals.

Medicare reimburses CAHs at 101 percent of their reasonable costs, rather than at the predetermined rates set by the Outpatient Prospective Payment System (OPPS). Medicare calculates outpatient coinsurance amounts differently for beneficiaries who receive services at CAHs than for beneficiaries who receive services at most other hospitals. Beneficiaries who receive services at CAHs pay coinsurance amounts based on CAH charges, consistent with payment based on reasonable cost. Under the OPPS, beneficiary copayment is based on the OPPS payment rate. In the final rule on OPPS payment policies for calendar year 2014, CMS estimated that, in aggregate, beneficiary liability would be 21.7 percent of OPPS payment. CAH charges are typically higher than the reasonable costs associated with CAH services or the OPPS rates that most hospitals receive.

The OIG report relied on 2009 and 2012 claims data to calculate the percentages and amounts of coinsurance that Medicare beneficiaries paid toward the costs for outpatient services at CAHs. OIG also calculated the percentages and amounts of coinsurance that Medicare beneficiaries would have paid at hospitals paid under the OPPS for 10 frequently provided outpatient services at CAHs.

Coinsurance based on charges resulted in Medicare beneficiaries paying nearly half the costs for outpatient services at CAHs. In 2012, beneficiaries paid approximately \$1.5 billion of the estimated \$3.2 billion cost for CAH outpatient services (47 percent). Approximately 681,000 Medicare beneficiaries who received outpatient services at CAHs paid, on average, more than half of the costs in coinsurance, including 146,000 who paid more than 75 percent of the costs in coinsurance. Additionally, the average percentage of costs that Medicare beneficiaries paid in

coinsurance for outpatient services at CAHs increased two percentage points from 45 percent in 2009 to 47 percent in 2012. Finally, beneficiaries paid between two and six times the amount in coinsurance for 10 frequently provided outpatient services at CAHs than they would have for the same services at hospitals paid under the OPSS.

The OIG's recommendation and CMS' response to that recommendation are discussed below.

OIG Recommendation

The OIG recommends that CMS seek legislative authority to modify how coinsurance is calculated for outpatient services received in CAHs.

CMS Response

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

ACKNOWLEDGMENTS

This report was prepared under the direction of Ann Maxwell, Regional Inspector General for Evaluation and Inspections in the Chicago regional office; Thomas Komaniecki, Deputy Regional Inspector General; and Laura Kordish, Deputy Regional Inspector General.

Lisa Minich served as the team leader for this study, and Brian Jordan served as the lead analyst. Central office staff who provided support include Clarence Arnold, Heather Barton, and Christine Moritz.

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