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**Offices In**
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Washington, D.C.
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August 11, 2016

**VIA FIRST CLASS MAIL AND EMAIL**
Kevin McDonald, Chief
Certificate of Need Division
Maryland Health Care Commission
4160 Paterson Avenue
Baltimore, Maryland 21215

**Re: Massachusetts Avenue Surgery Center, LLC**
**Matter No. 16-15-2378**
**Responses to Completeness Questions**

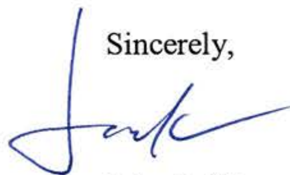
Dear Mr. McDonald:

On behalf of Massachusetts Avenue Surgery Center, LLC ("MASC"), we are hereby submitting the required six (6) copies of our Responses to July 27, 2016 Completeness Questions regarding the above-referenced project. We will also provide Word and electronic copies of our responses and exhibits as appropriate.

I hereby certify that a copy of this response has also been forwarded to the appropriate local health planning agency, as noted below.

If any further information is needed, please let us know.

Sincerely,



John J. Eller

JJE/tjr
Enclosures
cc: Ms. Ulder Tillman, Health Officer
Montgomery County Health Planning Agency
Joel Riklin, Program Manager
Center for Health Care Facilities Planning & Development
William Chan, Health Policy Analyst
Maryland Health Care Commission
Angela Clark, Health Policy Analyst
Maryland Health Care Commission

cc: Suellen Wideman, Assistant Attorney General
Maryland Health Care Commission
Ms. Ruby Potter
Health Facilities Coordination Office
Randall H. Gross, Executive Director
Massachusetts Avenue Surgery Center
Andrew Solberg, CON Consultant
A.L.S. Healthcare Consultant Services

Massachusetts Avenue Surgery Center
Docket No.: 16-15-2378
Responses to July 27, 2016 Completeness Questions

## PART1 – PROJECT IDENTIFICATION AND GENERAL INFORMATION

1. **The attached lease arrangement expired on the 30th day of November, 2014 (exhibit 3). Please provide a copy of the current lease agreement, or show that the applicant exercised a renewal option along with the terms for this updated arrangement.**

Please see Exhibit 13.

## PART II – PROJECT BUDGET

2. **Please discuss how the $13,219 in contingency allowance and the $1,928 in inflation allowance were calculated (Table E).**

Contingency was calculated at 7.5% of the sum of Renovation: Building, Fixed Equipment (not included in construction), Architect/Engineering Fees, and Permits (Building, Utilities, Etc.) on Table E – Project Budget in the CON Application Table Packet.

| Item | Amount |
|---|---|
| Building | $150,000 |
| Fixed Equipment (not included in construction) | |
| Architect/Engineering Fees | $11,250 |
| Permits (Building, Utilities, Etc.) | $15,000 |
| ***SUBTOTAL*** | **$176,250** |

| | |
|---|---|
| | $176,250 |
| X | 7.5% |
| | **$13,218.75** |

Inflation was calculated according to the methodology and Building Cost Index in the *IHS Economics Healthcare Cost Review* that the Commission uses and has posted on its website.

| | | | | | |
|---|---|---|---|---|---|
| Estimate Date | 2016:2 | | | | |
| Midpoint of Construction | 2017:1 | | | | |
| Step 1 | 2016:2 | CIS Proxy | 1.138 | | *B* |
| | 2017:1 | CIS Proxy | 1.149 | | *C* |
| | *C/B* | | | 1.00966608 | *D* |

| | |
|---|---|
| Total Current Capital Costs | $199,469 |
| Inflated Total Current Capital Costs | $201,397 |
| Inflation | **$1,928** |

3. **In Table F, please clarify whether the procedures previously performed in the Procedure Room (CY or FY 2014 thru 2016) are now included in the four ORs (CY or FY 2017 thru 2019). If so, please separate and report the number of surgical case procedures only that are performed in the four ORs.**

As explained on page 30 of the CON application, the procedure room cases are not included in the 2014, 2015, and 2016 OR Cases. However, they are included in the 2017, 2018, and 2019 cases on Table 5, as they will be performed in the additional OR.

Below is an alternate to the Table 5 (on pages 30-31 of the application) that deletes the Pain cases for the four physicians who currently perform them in the Procedure Room.

Table 5 (Alternate)
Historic and Projected OR Cases
Not Including Pain Cases
MASC
By Physician

| Physcian | Specialty | 2014 | 2015 | % Change | 2016 Budgeted | % Change | 2017 | % Change | 2018 | % Change | 2019 | % Change |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| *Barter,James* | *GYN* | 160 | 125 | -22% | 125 | 0.0% | 129 | 3.3% | 133 | 3.3% | 138 | 3.3% |
| *Beiser,Ian* | *POD* | 70 | 120 | 71% | 120 | 0.0% | 124 | 3.3% | 128 | 3.3% | 132 | 3.3% |
| *Bernstein,Steven* | *ORTHO* | 0 | 3 | N/A | 5 | 66.7% | 5 | 3.3% | 5 | 3.3% | 6 | 3.3% |
| *Busch,Rebecca* | *GYN* | 71 | 71 | 0% | 70 | -1.4% | 72 | 3.3% | 75 | 3.3% | 77 | 3.3% |
| *Coleman,Pamela* | *URO* | 70 | 72 | 3% | 70 | -2.8% | 72 | 3.3% | 75 | 3.3% | 77 | 3.3% |
| *Danziger,Marc* | *ORTHO* | 174 | 194 | 11% | 195 | 0.5% | 201 | 3.3% | 208 | 3.3% | 215 | 3.3% |
| *Dunne, Jr.,Edward* | *URO* | 69 | 67 | -3% | 70 | 4.5% | 72 | 3.3% | 75 | 3.3% | 77 | 3.3% |
| *Engel,Jason* | *URO* | 139 | 70 | -50% | 14 | -80.0% | 14 | 3.3% | 15 | 3.3% | 15 | 3.3% |
| *Faucett, Scott* | *ORTHO* | | | N/A | 45 | N/A | 46 | 3.3% | 48 | 3.3% | 50 | 3.3% |
| | | | | | | | | | | | | |
| *Firestone,Lee* | *POD* | 74 | 70 | -5% | 70 | 0.0% | 72 | 3.3% | 75 | 3.3% | 77 | 3.3% |
| *Gilbert,James* | *ORTHO* | 206 | 208 | 1% | 210 | 1.0% | 217 | 3.3% | 224 | 3.3% | 231 | 3.3% |
| *Goicochea,Juvenal* | *GEN* | 138 | 134 | -3% | 135 | 0.7% | 139 | 3.3% | 144 | 3.3% | 149 | 3.3% |
| *Goral,Antoni* | *ORTHO* | 0 | 0 | N/A | 45 | N/A | 46 | 3.3% | 48 | 3.3% | 50 | 3.3% |
| *Gowda,Ashok* | *ORTHO* | 0 | 1 | N/A | 25 | 2400.0% | 26 | 3.3% | 27 | 3.3% | 28 | 3.3% |
| *Guidi,Eric* | *ORTHO* | 104 | 113 | 9% | 115 | 1.8% | 119 | 3.3% | 123 | 3.3% | 127 | 3.3% |
| | | | | | | | | | | | | |
| *Kumar,Shailendra* | *URO* | 12 | 9 | -25% | 15 | 66.7% | 15 | 3.3% | 16 | 3.3% | 17 | 3.3% |
| *Lavine,Peter* | *ORTHO* | 47 | 74 | 57% | 75 | 1.4% | 77 | 3.3% | 80 | 3.3% | 83 | 3.3% |
| *Levitt,Louis* | *ORTHO* | 85 | 89 | 5% | 90 | 1.1% | 93 | 3.3% | 96 | 3.3% | 99 | 3.3% |
| *Lieberman,Murray* | *URO* | 72 | 70 | -3% | 70 | 0.0% | 72 | 3.3% | 75 | 3.3% | 77 | 3.3% |
| *Litvak,Juan* | *URO* | 62 | 69 | 11% | 70 | 1.4% | 72 | 3.3% | 75 | 3.3% | 77 | 3.3% |

| Physcian | Specialty | 2014 | 2015 | % Change | 2016 Budgeted | % Change | 2017 | % Change | 2018 | % Change | 2019 | % Change |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Losee,John | URO | 152 | 143 | -6% | 150 | 4.9% | 155 | 3.3% | 160 | 3.3% | 165 | 3.3% |
| Maruf,Nizamuddin | URO | 91 | 79 | -13% | 85 | 7.6% | 88 | 3.3% | 91 | 3.3% | 94 | 3.3% |
| Ochiai,Derek | ORTHO | 59 | 60 | 2% | 60 | 0.0% | 62 | 3.3% | 64 | 3.3% | 66 | 3.3% |
| Pillai-Allen,Anita | GYN | 1 | 2 | 100% | 2 | 0.0% | 2 | 3.3% | 2 | 3.3% | 2 | 3.3% |
| Radolinski,Bartholomew | URO | 78 | 73 | -6% | 75 | 2.7% | 77 | 3.3% | 80 | 3.3% | 83 | 3.3% |
| Raizman,Noah | ORTHO | 179 | 231 | 29% | 250 | 8.2% | 258 | 3.3% | 267 | 3.3% | 276 | 3.3% |
| Robles,Erin | POD | 4 | 12 | 200% | 15 | 25.0% | 15 | 3.3% | 16 | 3.3% | 17 | 3.3% |
| | | | | | | | | | | | | |
| Rosenblum,Mark | URO | 69 | 90 | 30% | 90 | 0.0% | 93 | 3.3% | 96 | 3.3% | 99 | 3.3% |
| Scheer,Mark | ORTHO | 99 | 91 | -8% | 95 | 4.4% | 98 | 3.3% | 101 | 3.3% | 105 | 3.3% |
| Schwartz,Erika | POD | 42 | 50 | 19% | 50 | 0.0% | 52 | 3.3% | 53 | 3.3% | 55 | 3.3% |
| Shin,Paul | URO | 103 | 73 | -29% | 1 | -98.6% | 1 | 3.3% | 1 | 3.3% | 1 | 3.3% |
| Shrout,Joseph | ORTHO | 60 | 83 | 38% | 85 | 2.4% | 88 | 3.3% | 91 | 3.3% | 94 | 3.3% |
| Siram,Gautam | ORTHO | 1 | 21 | 2000% | 70 | 233.3% | 72 | 3.3% | 75 | 3.3% | 77 | 3.3% |
| Stein,Benjamin | ORTHO | 0 | 135 | N/A | 150 | 11.1% | 155 | 3.3% | 160 | 3.3% | 165 | 3.3% |
| Sterling,Kathleen | URO | 5 | 25 | 400% | - | -100.0% | - | N/A | - | N/A | - | N/A |
| | | | | | | | | | | | | |
| Thiel,James | ORTHO | 34 | 27 | -21% | 50 | 85.2% | 52 | 3.3% | 53 | 3.3% | 55 | 3.3% |
| Townsend,Lewis | GYN | 142 | 124 | -13% | 125 | 0.8% | 129 | 3.3% | 133 | 3.3% | 138 | 3.3% |
| Vicente,Gonzalo | OPTH | 46 | 71 | 54% | 70 | -1.4% | 72 | 3.3% | 75 | 3.3% | 77 | 3.3% |
| Weiss,James | ORTHO | 58 | 63 | 9% | 4 | -93.7% | 4 | 3.3% | 4 | 3.3% | 4 | 3.3% |
| Wolff,Andrew | ORTHO | 32 | 49 | 53% | 70 | 42.9% | 72 | 3.3% | 75 | 3.3% | 77 | 3.3% |
| **Total** | | 2,808 | 3,061 | 9% | **3,131** | 2.3% | 3,234 | 3.3% | 3,341 | 3.3% | 3,451 | 3.3% |

Without the Pain cases, the minutes per case is calculated as follows:

| | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|
| Total Cases | 3,131 | 3,234 | 3,341 | 3,451 |
| Total Joint Replacement (TJR) Cases | 75 | 120 | 150 | 175 |
| Non-TJR or Pain Cases | 3,056 | 3,114 | 3,191 | 3,276 |
| Non-TJR or Pain Min/Case | 72.22 | 72.22 | 72.22 | 72.22 |
| Non-TJR or Pain Min | 220,714 | 224,927 | 230,469 | 236,626 |
| TJR Min/Case | 128.4 | 128.4 | 128.4 | 128.4 |
| TJR Min | 9,630 | 15,408 | 19,260 | 22,470 |
| Total Min/Case | 73.57 | 74.31 | 74.75 | 75.07 |

MASC would need 3.53 ORs if the Pain cases are not included.

| | 2014 | 2015 | 2016 Budgeted | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|---|
| OR Cases | 2,808 | 3,061 | 3,131 | 3,234 | 3,341 | 3,451 |
| Min/Case | 68.21 | 72.68 | 73.57 | 74.31 | 74.75 | 75.07 |
| OR Mins. | 191,520 | 222,480 | 230,344 | 240,335 | 249,729 | 259,096 |
| TAT/Case | 25 | 25 | 25 | 25 | 25 | 25 |
| TAT Mins | 70,200 | 76,525 | 78,275 | 80,858 | 83,526 | 86,283 |
| Total Mins | 261,720 | 299,005 | 308,619 | 321,193 | 333,255 | 345,379 |
| Capacity/OR | 97,920 | 97,920 | 97,920 | 97,920 | 97,920 | 97,920 |
| Needed ORs | 2.67 | 3.05 | 3.15 | 3.28 | 3.40 | 3.53 |

While MASC needed more than three ORs in 2015 and needs a fourth OR now, MASC believes that it is appropriate to include the Pain cases in the future OR need projections. As explained on pages 29-30 of the CON application, the cases meet the MHCC's definition of "Surgical Cases" in the State Health Plan, and they are appropriate to be performed in ORs.

## PART III – APPLICANT HISTORY, STATEMENT OF RESPONSIBILITY, AUTHORIZATION AND RELEASE OF INFORMATION, AND SIGNATURE

**4. Do the physicians identified as the MASC Physician Board represent the Board of Trustees (item 1)? Please provide the names of the officers of MASC, LLC.**

Yes, the individuals named in the application, and repeated below along with identification of their roles as Officers, do constitute the MASC Board.

| Name | Address | Role |
|---|---|---|
| Danziger, Marc, MD | 1850 M St. NW<br>#750<br>Washington, DC 20036 | Secretary/Treasurer |
| Klaiman, Mark, MD | Point Performance Medicine<br>6400 Goldsboro Road<br>Suite 340<br>Bethesda, MD 20817 | Board Member |
| Levitt, Louis, MD | 1850 M St. NW<br>#750<br>Washington, DC 20036 | Chairman |

| Losee, John, MD | 1147 20th Street, NW<br>Suite 400<br>Washington, DC 20036 | Vice Chairman |
|---|---|---|

| Townsend, Lewis, MD | Capital Women's Care<br>10215 Fernwood Road; Suite 250<br>Bethesda, MD 20817 | Board Member |
|---|---|---|

**PART IV – CONSISTENCY WITH GENERAL REVIEW CRITERIA AT COMAR 10.24.01.08G(3)**
**The State Health Plan**

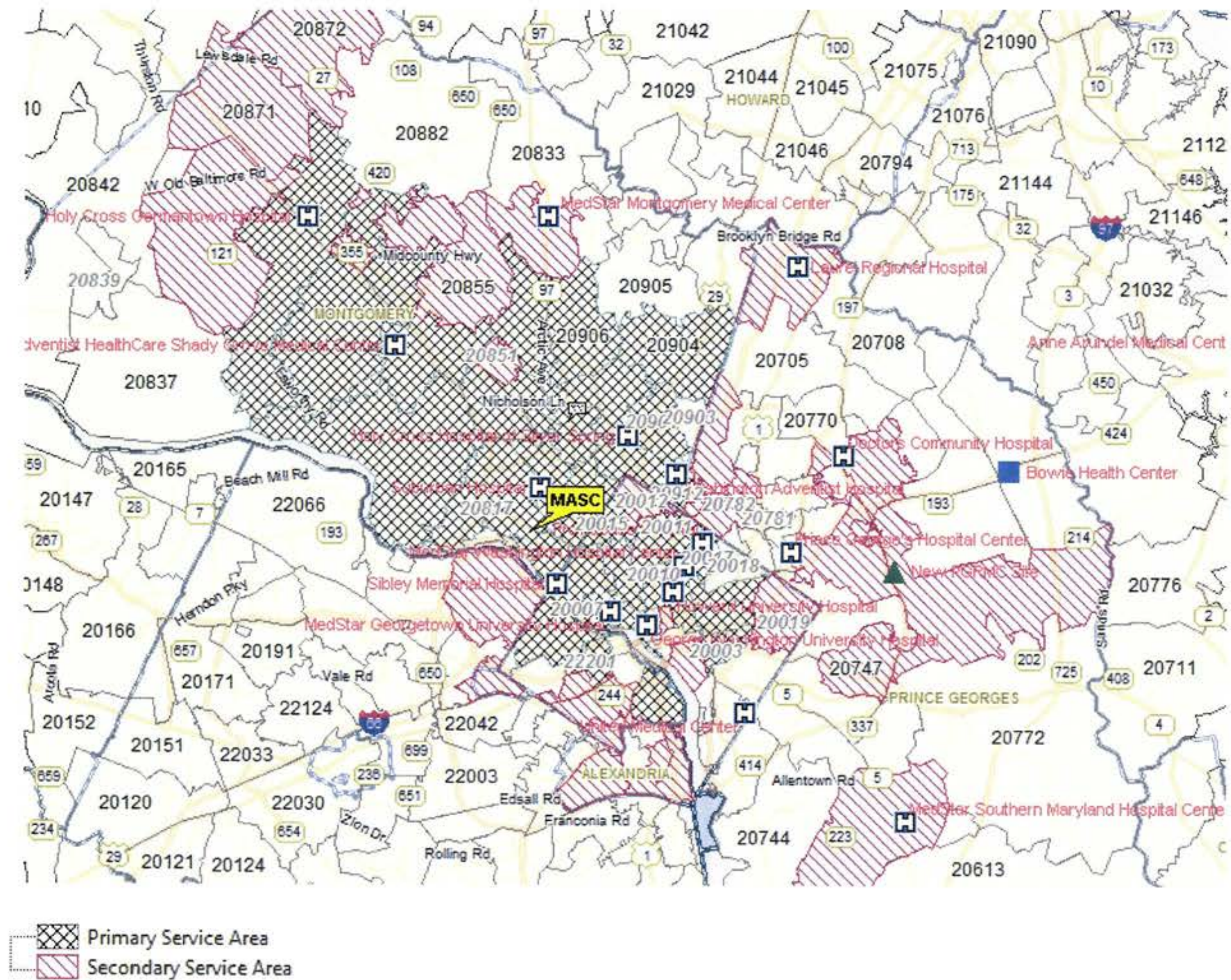
5. ***Standard .05A(1) – Information Regarding Charges.*** **Please provide a copy of MASC's policy regarding Information regarding charges. More specifically, guidelines to supplying the information to patients and their families for the range and types of services provided by MASC.**

   Please see Exhibit 14.

6. ***Standard .05B(1) – Service Area.*** **Please define and identify the geographic areas included in the primary and secondary service area for MASC. The use of a map such as on p. 27 of the CON application would be helpful in identifying the primary and secondary service area.**

The following map shows MASC's Primary Service Area (the Zip Codes from which the top 60% of cases derive) and Secondary Service Area (the next 15%). MASC defines its Service Area as 75% of its cases because the next 10% includes 39 Zip Codes, all of which contribute fewer than 16 cases.

**Figure 1**
**MASC's Primary and Secondary Service Area**




7. ***Standard .05B(6) – Patient Safety.* The patient safety standard requests that the applicant document how patient safety was taken into account while planning the project. Please answer the following:**
   a. **The applicant stated that the current security arrangement works well and will be maintained, please describe the current security arrangement and explain how it ensures efficiency and safety.**

Public access to the Massachusetts Avenue Surgery Center is limited to the main entrance where a full time receptionist sits. All other entry points are secured by a push button coded lock system. Access to the code is limited to MASC staff, physicians and certain key vendors and is periodically changed. After 6pm both the front doors and elevators are locked and require a key card to access the building and the 4th floor where MASC is located. MASC also has an alarm system installed that has the panic/emergency button feature that will directly contact the authorities when engaged.

**b. Provide the type of finish selections will be included with this room renovation and how it will maximize the applicant's ability to sanitize the space.**

The existing procedure room has full height acrovyn along with a sheet vinyl welded floor with integral base. Acrovyn is often used in operating rooms as it is an impervious, vinyl wall protection material that is easily maintained, scrubbable, and resistant to damage from cleaning chemicals. Similarly, a welded sheet vinyl floor with integral coved base provides a seamless floor surface which wraps up wall to form the wall base material. This system eliminates joints which could otherwise be a point contamination. These materials are used in MASC's existing ORs, as well. The existing ceiling will be changed to a hard ceiling. All of these surfaces are seamless and easily sanitized.

**c. What adjustments need to be made to the medical gases, call systems and power in the room, and how will those adjustments provide a safer environment for the patients to receive treatment?**

There are no adjustments needed to the existing medical gases (2 oxygen, 3 vacuum, 1 medical air) that are currently in the new OR to bring it up to acceptable standards.

Existing power in the room is compliant , providing 18 single receptacles (at least 2 on each wall). Normal power and emergency is distributed amongst the devices.

MASC will have to extend the HVAC system that is serving the existing ORs to the new OR and sterile area to provide the required humidity control, air changes and filtration per the FGI Guidelines.

The call system that currently resides in the three existing ORs will be extended to the new OR providing a safer environment for the patients receiving their care in this room. The existing nurse call system in the existing three ORs is compliant (Emergency Staff Assist and Code).

This new OR will meet the FGI Guidelines and all required codes, just as the existing three ORs do. Such compliance helps assure patient safety.

Since MASC opened, it has always included patient safety in its plans and operation. Among the factors that MASC has implemented to enhance patient safety are:

- Operative / Post Operative Complications
  - Standardized OR equipment layout
  - Immediate access to supplies
  - Proper HVAC air flow, changes and filtration
  - Sterile air field around OR table
  - Separation of sterile area and materials from and dirty area and materials

- Correct Tube – Correct Connection – Correct Hole
  - Standardized headwall layouts
  - All gases are well labeled and standardized

- Wrong Site Surgery
  - Patient education
  - Interaction between doctor and patient in pre-op
  - Nursing staff also reviews side with patient
  - In the operating room, the surgical team always performs a mandatory Time Out prior to performing the surgery to review the procedure, patient's medical history, the site of the surgery, and any other pertinent information.

- Patient Falls
  - Patient visibility improved by centralized nurse stations
  - Slip resistant floor surfaces

**d. The applicant stated that the new OR will be designed similarly to the existing ORs, describe the similarities and differences in how the current and proposed OR rooms improve patient safety.**

As stated above, Planning for the new OR was done with standardization in mind. The new OR will be designed with a layout similar to that of the three existing ORs, which minimizes the need to retrain staff for a different layout and allows staff to move from one OR to another without confusion, thus improving patient safety.

The new OR will have all will have similar finishes to the existing ORs. Finishes of the floors, walls, and other areas are all consistent and are specified to maintain a sterile environment and minimize operative and post-operative infection risk. Similarly, mechanical filtration is designed to maintain optimum levels of air quality. All cleanable surfaces on the walls and floors are consistent. As stated previously, a new hard ceiling will be installed in lieu of the existing acoustical ceiling.

Other than the physical size of the room, the plans are to design it the same as the existing ORs.

**<u>Availability of More Cost-Effective Alternatives</u>**

**8. What are the costs and timeframes associated with the alternatives?**

MASC identified three different alternatives.

1. Lease additional space

As stated in the CON application, MASC considered attempting to lease more space in the building. However, doing so would require redesigning the OR suite, would take more time

and would require much more renovation. As no space is currently available adjacent to MASC, MASC would have had to renovate enough space for an entire four OR ASF, including pre-surgical and post-surgical recovery areas, a waiting area and other support spaces.

MASC currently has 15,740 square feet. If it were to move, MASC would consider increasing to 16,250 in order to have enough square footage to grow in the future. MASC estimated that the project cost would have been approximately $400 per square foot, or $6,500,000.

A project of this scope would have taken approximately six months to accomplish, meaning that MASC would have had to pay rent on both its existing space as well as the new space.

MASC rejected this option, given that it had the ability to convert its Procedure Room to an operating room at significantly lower cost.

2. Do nothing

Even though doing nothing has no capital cost for MASC, MASC decided it was not cost effective. It would require surgeons to increase the number of cases that they would have to do at many additional sites. The need to split the caseload among facilities because of MASC capacity limitations is exactly the problem that the MASC practitioners are attempting to resolve. It limits patient options to choose where the surgery will be performed, and forces many cases to be done in more expensive hospital settings. Further, it requires the physicians to travel to various sites around the region to be able to perform the surgery, which is inefficient for the physicians, as the travel time limits the number of cases a physician can handle in a timely fashion, and the amount of time that can be devoted to the practice of medicine. Moreover, this results in delayed scheduling, which is undesirable from the patient's perspective. Maintaining the status quo simply is not a desirable alternative. MASC already needs more than 3 ORs and will need more than 4 ORs next year. Doing nothing would force the physicians to split their cases among different facilities.

3. The existing project

While the existing project does have a capital cost, MASC is already operating in excess of what the MHCC considers optimal utilization of its three ORs. In addition, as described above, MASC has had to turn cases away because it simply has no available OR time. And with an increasing number of TJR cases (which have significantly longer OR times), the situation will only grow worse. MASC decided to address this in the manner that cost the least and that could be accomplished in a short amount of time.

## Viability of the Proposal

9. **Please describe the relationship and history or length of engagement between MASC LLC and Aronson LLC (exhibit 8). How is Aronson LLC "familiar with the finances of MASC LLC," and what knowledge does Aronson have on the applicant's financial liquidity?**

Aronson LLC has been retained by MASC since 2013 for financial consulting and tax preparation. As such, they are completely familiar with MASC's finances, operation, retained earnings, distributions, and liquidity. Aronson is a major accounting firm in the Washington region (located in Rockville) and provides a large array of services, including assurance, tax, and financial consulting to the Construction, Real Estate, Government Contract Services, Technology, Nonprofit and Association, and, obviously, Health Care industries.

## Impact on Existing Providers

10. **Page 7 of the Executive Summary of the Project stated that the applicant has been redirecting many of the Urologic and Gynecological cases requiring general anesthesia back to a more expensive and less efficient acute care setting. Please provide the annual number of urologic and gynecological cases redirected over the past three years.**

The number of cases that were performed at Suburban Hospital because of scheduling conflicts and other limited capacity issues at MASC were 538 in 2015 and 342 year to date in 2016. These were predominantly Urology cases.

11. **Provide a summary description of the proposed project's impact on:**
    a. **The payer mix of all other existing health care providers that are likely to experience some impact on payer mix as a result of this project.**

MASC does not anticipate any material change to any other facility's payor mix. Many of the cases that will be performed in the additional OR are cases that are currently being performed at MASC and which constitute the current payor mix. When all of the cases are counted, MASC is projecting that it will be adding only 390 cases between 2016 and 2019. (4,381 – 3,991 = 390) MASC does not believe that any of these cases will come from other FASFs. Rather, they are a function of population growth and movement of some cases (such as the total joint replacements) from hospitals. MASC does not believe that the impact of such a small number of cases will result in any payor mix change. While the additional total joints in FASCs are currently paid only by commercial insurers, Medicare is currently considering doing so, and MASC believes that the overall payor mix for the additional cases will generally mirror its current payor mix. As shown in the CON application's Exhibit 1, Table G (Table G.

Revenues & Expenses, Uninflated - Entire Facility), MASC does not anticipate any changes in its own payor mix.

**b. Access to health care services for the service area population that will be served by the project (State and support the assumptions used in this analysis of the impact on access).**

This project will improve the access for the service area population to high quality, lower cost surgery.

It is well documented that the cost of surgery at ASFs is lower than at hospitals. A 2014 study by the Office of Inspector General (*Medicare And Beneficiaries Could Save Billions If CMS Reduces Hospital Outpatient Department Payment Rates For Ambulatory Surgical Center-Approved Procedures To Ambulatory Surgical Center Payment Rates*, See Exhibit 15) found that:

> Medicare saved almost $7 billion during calendar years (CYs) 2007 through 2011 and could potentially save $12 billion from CYs 2012 through 2017 because ASC rates are frequently lower than outpatient department rates for surgical procedures. In addition, Medicare could generate savings of as much as $15 billion for CYs 2012 through 2017 if CMS reduces outpatient department payment rates for ASC-approved procedures to ASC payment levels for procedures performed on beneficiaries with low-risk and no-risk clinical needs.
>
> Source: https://oig.hhs.gov/oas/reports/region5/51200020.asp

On June 14, 2016, the Ambulatory Surgery Center Association reported on its website on another study.

> An analysis of private health insurance claims from across the country found ambulatory surgery centers (ASCs) reduce the cost of outpatient surgery by more than $38 billion dollars per year by providing a lower cost site of care compared to hospital outpatient departments (HOPDs). The research concluded that ASC prices are significantly lower than HOPD prices for the same procedures throughout the country, regardless of payer.
>
> The analysis was conducted by Healthcare Bluebook™, a national provider of quality and cost data for healthcare services in partnership with HealthSmart®, the nation's largest independent administrator of health plans for self-funded employers. The Ambulatory Surgery Center Association (ASCA), representing the interests of more than 5,400 outpatient surgery centers, contributed technical assistance and expertise to the study.
>
> The study also concluded that ASC patients' out-of-pocket costs are reduced by more than $5 billion annually through lower deductible and coinsurance payments. In Charleston, West Virginia, for example, the researchers found that cataract patients with a silver plan from the exchanges would save $566 in out-of-pocket costs by choosing an ASC.
>
> Source: www.ascassociation.org/asca/aboutus/pressroom/2016/ascs-reduce-outpatient-surgery-costs-for-commercially-insured-patients-by-38-billion-annually

This is borne out by local cost comparisons. Table 9 shows the average charge for procedures at two nearby hospitals (Holy Cross Hospital of Silver Spring and Johns Hopkins Suburban Hospital) taken from their websites on 7/31/2016 and the average allowable reimbursement (including any copays or self-pay) for the same procedures at MASC. This comparison is valid because hospitals receive charges (with small discounts for fast payment). Thus, the hospitals' average charges are comparable to ASFs' allowable reimbursement. (As MASC has explained in the past, actual charges at ASFs are irrelevant, as payors only allow certain levels of reimbursement by procedure.) MASC has included all of the procedures that it believes are comparable to those performed at MASC. In all of the procedures except Outpatient Spinal Injection at Suburban Hospital, MASC's reimbursement is materially lower at MASC than at the hospitals.

**Table 9**
**Average Charge at Area Hospitals**
**Average Allowable Reimbursement at MASC**
**2016**

| | Average Charge | MASC Average Allowable Reimbursement |
|---|---|---|
| **Holy Cross Hospital** | | |
| *Inpatient Service* | | |
| Laparoscopic Appendectomy | $10,019 | $2,213 |
| Laparoscopic Cholecystectomy | $12,154 | $3,303 |
| *Outpatient Service* | | |
| Laparoscopic Supracervical Hysterectomy | $9,599 | $4,016 |
| Laparoscopically Assisted Vaginal Hysterectomy | $7,673 | $3,112 |
| Excision or Destruction of Lesion of Uterus- Open | $4,529 | $2,902 |
| Laparoscopic Cholecystectomy | $6,693 | $3,303 |
| Laparoscopic Appendectomy | $7,041 | $2,213 |
| Right Synovectomy, Knee | $7,188 | $1,239 |
| **Suburban Hospital** | | |
| *Inpatient Service* | | |
| Total Knee Replacement | $16,792 | $12,975 |
| Total Hip Replacement | $16,353 | $12,906 |
| Appendectomy | $9,036 | $2,353 |
| Laparoscopic Cholecystectomy | $11,400 | $3,303 |
| *Outpatient Service* | | |
| Spinal Injection | $742 | $863 |
| Laparoscopic Cholecystectomy | $6,164 | $3,303 |
| Knee Cartilage Repair | $3,497 | $3,296 |
| Breast Biopsy | $4,330 | $1,605 |

Sources: www.holycrosshealth.org/body.cfm?id=1736&fr=true,

www.hopkinsmedicine.org/suburban_hospital/planning_your_visit/financial_information/estimated_charges.html, and MASC

Clearly, if the procedures are performed on an outpatient basis, it will cost less. And, in most cases, if they are performed at MASC, it will cost less. Providing another OR at MASC will improve access to patients to this lower cost option.

The current trend in health insurance involves high deductible plans. Consequently, patients are having to go out of pocket for much higher amounts and consequently prefer to have their surgeries at an ASF where they will save between 40-50% of what their out of pocket would be at a hospital.

Health plans are incentivizing surgeons by paying them a premium if they perform their surgeries at an in-network ASF rather than a hospital or out-of-network ASF. Health plans are also contractually requiring surgeons to take their patients to an in network ASF. In addition, many health plans are attempting to control where their subscribers are having their surgeries by requiring that many of the surgeries get pre-authorized.

This is not limited to MASC. For example in the CON application filed by The Johns Hopkins Green Spring Station Surgery Center (Docket No. 15-03-2369), Hopkins said:

> First, the Department is increasingly finding that due to insurance changes and patient preference, there is an increasing demand for a freestanding unregulated ambulatory surgery center for faculty to use. Faculty are already experiencing insurance denials for cases performed at a higher cost in a hospital setting.
> Source: CON Application, P. 57

Furthermore, MASC is considered a model for other ASF operators on how to run a high quality, efficient facility. Nearly every other month, managers of other ASFs visit MASC to tour it and see how a well-run, high quality facility can operate. In addition, the Ambulatory Surgery Center Association ("ASCA") uses MASC whenever the press has questions or wants to tour an ASC and when health care providers from other countries need education on, and a tour of, a high quality ambulatory surgery facility. For example, in October 2015, ASCA, in response to a request from the U.S. Department of Commerce, asked MASC to host a team of approximately 25 people from a Eurasian Delegation, allow them to tour MASC, and answer question. ASCA has also used MASC in filming a national education video for public awareness on what an ASF is. This video can be viewed at:

http://www.advancingsurgicalcare.com/whatisanasc/whatisanasc.

Enabling MASC to have the additional OR capacity that it needs will improve access to a high quality, lower cost alternative.

**c. Costs to the health care delivery system.**

As shown in the response to Question 11.b, above (which is hereby incorporated into this response), the impact of increasing capacity at MASC will lead to lower costs for the health care system. As demonstrated in the articles, this is a well-established fact.

**d. The applicant's costs and charges, consistent with the information provided in the Project Budget, the projections of revenues and expenses, and the work force information.**

Since an ASF's charges are irrelevant, and the allowable reimbursement is set by payors, this project will have no impact on how much MASC can collect per case. The average amount of net revenue per case is solely dependent on case mix. As the CON application explains, MASC does anticipate that it will perform more Total Joint Replacements (TJRs) in the next few years, and, as Table 9 above shows, average reimbursement for TJRs is considerably higher than for other procedures. This will result in an increase in the average Net Revenue per case at MASC.

| | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|---|
| Total Cases | 3,402 | 3,761 | 3,991 | 4,105 | 4,241 | 4,381 |
| | | | | | | |
| Net Patient Services Revenue | $8,847,097 | $10,165,789 | $11,326,840 | $11,884,581 | $12,522,307 | $13,194,254 |
| Net Revenue/Case | $2,601 | $2,703 | $2,838 | $2,895 | $2,953 | $3,012 |

When comparing salaries per case, one also should include contracted services. One can see that the total increase in Salaries and Contracted Services is not material.

| | | | | | | |
|---|---|---|---|---|---|---|
| Salaries & Wages (including benefits) | $2,722,016 | $2,643,356 | $2,538,627 | $2,614,786 | $2,771,673 | $2,841,678 |
| Per Case | $800 | $703 | $636 | $637 | $654 | $649 |
| | | | | | | |
| Contractual Services | $1,744 | $50,863 | $56,672 | $59,463 | $62,654 | $65,739 |
| Per Case | $1 | $14 | $14 | $14 | $15 | $15 |
| Total/Case | $801 | $716 | $650 | $651 | $668 | $664 |

TJRs are very supply intensive, so it is not surprising that the Supply Cost per case will increase as the number of TJRs increases.

| | | | | | | |
|---|---|---|---|---|---|---|
| Supplies | $2,115,632 | $2,806,820 | $3,127,392 | $3,281,386 | $3,457,466 | $3,627,713 |
| Per Case | $622 | $746 | $784 | $799 | $815 | $828 |

The only expense that is directly related to this project (and not to case mix) is the facility depreciation, which, as Table G - Revenues and Expenses shows, will increase.

However, as shown in Table G, these expense increases will not adversely affect MASC's profitability.

Exhibits

13. Current Lease Amendment
14. Policy on Information on Charges
15. DHHS Office of the Inspector General Study
16. Affirmations

Exhibit 13.
Current Lease Amendment

# SECOND AMENDMENT TO LEASE

THIS SECOND AMENDMENT TO LEASE (this "Amendment") is made this 10th day of January 2012 by and between (i) 6400 GOLDSBORO, LLC, a Delaware limited liability company ("Landlord"), and (ii) MASSACHUSETTS AVENUE SURGERY CENTER, LLC, a Maryland limited liability company ("Tenant").

WITNESSETH

RECITALS:

R-1. Landlord and Tenant are parties to a Lease Agreement dated June 1, 2004 (the "Original Lease"), as amended by a First Amendment to Lease dated September 8, 2008 (the "First Amendment") for premises consisting of approximately 11,529 rentable square feet (the "Existing Premises") in the office building located at 6400 Goldsboro Road, Bethesda, Maryland 20817 (the "Building"). (The Original Lease, as amended by the First Amendment, is referred to hereinafter as the "Amended Lease." The Amended Lease, as amended by this Amendment, is referred to hereinafter as the "Lease.")

R-2. The Existing Premises are comprised of (i) Suite 400 on the fourth floor of the Building, which consists of 8,174 rentable square feet ("Suite 400"), and (ii) Suite 360 on the third floor of the Building, which consists of 3,355 rentable square feet ("Suite 360.")

R-3. The term of the Amended Lease expires on November 30, 2014 (the "Original Lease Expiration Date.")

R-4. Pursuant to this Amendment, Landlord and Tenant wish to (i) expand the Existing Premises to include Suite 450, which consists of approximately 7,566 rentable square feet on the fourth floor of the Building (the "Expansion Space"), (ii) extend the term of the Amended Lease, and (iii) modify certain other terms of the Amended Lease. The location of the Expansion Space is outlined on Exhibit A attached hereto. Suite 400 and the Expansion Space are referred to hereinafter collectively as the "Fourth Floor Premises." The Fourth Floor Premises constitutes the entire fourth floor of the Building.

NOW, THEREFORE, in consideration of the agreements herein contained, the parties hereby agree as follows:

1. Incorporation of Recitals and Exhibits. The Recitals set forth above and the Exhibits attached hereto are incorporated herein and made a part of this Amendment to the same extent as if set forth herein in full.

2. Extension of Lease Term.

A. The Lease Term with respect to the Fourth Floor Premises is hereby extended until the "Fourth Floor Lease Expiration Date" (as defined below), upon the same terms, covenants, and conditions as are set forth in the Amended Lease, as amended by this

Amendment. The Fourth Floor Lease Expiration Date shall be the last day of the thirteenth (13th) "Expansion Space Lease Year" (as defined below). Subject to Section 10 hereof regarding Suite 360, effective as of the date hereof, all references to "Lease Term" in the Lease shall mean the time period that commenced on the Commencement Date, and will end at midnight on the last day of the thirteenth (13th) Expansion Space Lease Year, unless sooner terminated pursuant to the Lease.

B. The term "Expansion Space Lease Year" means each and every consecutive twelve (12) month period starting on the "Expansion Space Rent Commencement Date" (as defined below) and ending on the last day of the Lease Term; provided, however, if the Expansion Space Rent Commencement Date occurs other than on the first day of a calendar month, the first Expansion Space Lease Year shall be that partial month plus the first full twelve (12) months thereafter.

C. The term "Expansion Space Rent Commencement Date" means the earlier of (i) July 1, 2012, or (ii) the date that Tenant begins doing business in the entirety (as opposed to less than all) of the Expansion Space.

D. At either party's request, the parties shall execute a declaration in the form attached hereto as Exhibit B (the "Expansion Space Declaration") specifying the Expansion Space Commencement Date, the Expansion Space Rent Commencement Date, and the other matters set forth therein. Either party's failure to execute the Expansion Space Declaration shall not affect the Expansion Space Commencement Date, the Expansion Space Rent Commencement Date or the Lease Term, as the same are determined by this Amendment.

3. Lease of the Expansion Space.

A. Landlord hereby leases to Tenant and Tenant hereby leases from Landlord the Expansion Space for a term commencing on the date Landlord delivers possession of the Expansion Space to Tenant (the "Expansion Space Commencement Date"), and ending on the Fourth Floor Lease Expiration Date. Except as otherwise provided in this Amendment, Tenant shall lease the Expansion Space subject to all of the same terms, covenants, and conditions that are applicable to Suite 400.

B. Upon Landlord, at its cost, shall relocate the tenant currently occupying the Expansion Space ("ACG") to other space in the Building, and promptly thereafter shall tender possession of the Expansion Space to Tenant. Landlord shall use commercially reasonable efforts to complete this relocation, and tender possession of the Expansion Space to Tenant no later than March 1, 2012; provided, however, that Landlord shall have no liability to Tenant for failing to deliver the Expansion Space to Tenant by March 1, 2012, but, in that event, clause (i) in the definition of the Expansion Space Rent Commencement Date (i.e., July 1, 2012) shall be pushed back one day for each day that elapses between March 1, 2012 and the date Landlord delivers the Expansion Space to Tenant.

C. Landlord shall deliver the Expansion Space to Tenant in its "as is" condition as of the date of this Amendment, but vacant and broom clean, and Landlord shall have no obligation to perform any work therein.

D. Except as otherwise provided in this Amendment, as of the Expansion Space Commencement Date, the Expansion Space shall be treated as part of the Premises for all purposes of the Lease, and, subject to the provisions of Section 10 below, the term "Premises" as used in the Lease shall refer collectively to the Existing Premises and the Expansion Space.

E. As of the Expansion Space Commencement Date, the Premises shall be increased to a total of 19,095 rentable square feet.

4. Leasehold Improvements to the Expansion Space; Expansion Space Allowance.

A. All work that Tenant desires to prepare the Expansion Space for its occupancy ("Tenant's Expansion Space Work"), including, without limitation, obtaining building permits and occupancy permits, shall be performed by Tenant at its cost (subject to the allowance hereinafter described) in accordance with Section 14 of the Original Lease. As per Section 14 of the Original Lease, Landlord agrees to join with Tenant in applying for all permits necessary to be secured from governmental authorities and to promptly execute such consents as such authorities may require in connection with Tenant's Expansion Space Work. Landlord approves the space plan attached to this Amendment as Exhibit C. Landlord agrees that at the expiration or earlier termination of this Lease, Tenant shall not be required to remove Tenant's Expansion Space Work or to restore the Expansion Space or the Existing Premises to their condition at the Expansion Space Commencement Date or the commencement date of the Original Lease, as the case may be, but shall be required to remove all of Tenant's equipment and other personal property from the Premises, and to repair any damage caused by this removal.

B. As part of Tenant's Expansion Space Work, Tenant shall install a meter for Tenant's consumption of electricity in the Fourth Floor Premises.

C. Landlord will provide to Tenant an allowance (the "Expansion Space Allowance") in the maximum amount hereinafter set forth, to be applied to the design, engineering and construction cost of Tenant's Expansion Space Work, including, without limitation, all demolition, demising, permits, construction, data and telecommunications cabling, and design and engineering fees. The maximum amount of the Expansion Space Allowance shall be Twenty Dollars ($20.00) multiplied by the total number of rentable square feet in the Expansion Space for a total of $151,320.00)].

D. Forty percent (40%) of the Expansion Space Allowance shall be payable by Landlord to Tenant within thirty (30) days after Tenant's Expansion Space Work has been fifty percent (50%) substantially completed (the "first payment"); and the final sixty percent (60%) of the Expansion Space Allowance shall be payable by Landlord to Tenant within thirty (30) days after Tenant substantially completes Tenant's Expansion Space Work, and provides Landlord an invoice and Tenant has taken possession, and moved into the Expansion Space (the "final payment"), *provided* that Tenant's payment request for any installment of the Expansion

Space Allowance must be accompanied by all (in the case of the final payment) or some of the following items (in the case of the first payment), as indicated:

(i) a certificate of Tenant's architect that Tenant's Expansion Space Work is fifty percent (50%) substantially completed, as to the first payment, and has been substantially completed, as to the final payment, in accordance with the approved plans;

(ii) a copy of the most comprehensive and up-to-date plans and specifications then available for Tenant's Expansion Space Work (final payment only); and

(iii) duly executed interim release of liens (first payment), and a final release of liens (final payment) executed by Tenant's general contractor and any and all subcontractors and/or materialmen supplying labor and/or materials in connection with Tenant's Expansion Space Work, in form and substance reasonably satisfactory to Landlord, acknowledging payment of one-half (first payment) and in full (final payment) for such labor and/or materials and fully and forever waiving any and all statutory and/or common law liens which might otherwise be asserted by them against the Premises (or any portion thereof), and the Building in connection with Tenant's Expansion Space Work to the applicable extent.

Landlord shall have no obligation to pay either the first payment or the final payment of the Expansion Space Allowance to Tenant's contractor unless and until thirty (30) days after Landlord has received a payment request with all required attachments properly supplied.

5. Fourth Floor Premises Base Rent.

A. Until the Expansion Space Rent Commencement Date, Tenant shall continue to pay base rent for Suite 400 as provided in the Amended Lease.

B. Commencing on the Expansion Space Rent Commencement Date, Tenant shall pay as base rent for the Fourth Floor Premises ("Fourth Floor Premises Base Rent"), the following amounts during the following time periods:

| Expansion Space Lease Year | Annual Fourth Floor Premises Base Rent | Monthly Fourth Floor Premises Base Rent |
|---|---|---|
| Lease Year 1 | $469,524.20 | $39,127.02 |
| Lease Year 2 | $482,431.00 | $40,202.58 |
| Lease Year 3 | $495,652.60 | $41,304.38 |
| Lease Year 4 | $509,346.40 | $42,445.53 |
| Lease Year 5 | $523,355.00 | $43,612.92 |
| Lease Year 6 | $537,678.40 | $44,806.53 |
| Lease Year 7 | $552,474.00 | $46,039.50 |
| Lease Year 8 | $567,741.80 | $47,311.82 |
| Lease Year 9 | $583,324.40 | $48,610.37 |
| Lease Year 10 | $599,379.20 | $49,948.27 |
| Lease Year 11 | $615,906.20 | $51,325.52 |
| Lease Year 12 | $632,905.40 | $52,742.12 |

| Lease Year 13 | $650,376.80 | $54,198.07 |
|---|---|---|

Fourth Floor Premises Base Rent shall be payable in equal monthly installments in advance in the same manner as base rent is payable with respect to the Existing Premises. If the Expansion Space Rent Commencement Date is a day other than the first of a month, the monthly installment of Fourth Floor Base Rent for that month shall be prorated, and shall be due and payable on the Expansion Space Rent Commencement Date.

6. Fourth Floor Premises Base Rent Net of Electric. The Fourth Floor Premises Base Rent is "net of electric," and, therefore, commencing with the Expansion Space Rent Commencement Date and continuing for the remainder of the Lease Term, Tenant shall pay for the cost of electricity consumed by Tenant in the Fourth Floor Premises, as determined by a meter to be installed by Tenant as part of Tenant's Expansion Space Work. Tenant shall make these payments directly to the utility providing electric service to the Building. Because Tenant is paying its own electricity directly, commencing with the Expansion Space Rent Commencement Date and continuing for the remainder of the Lease Term, electricity costs for all tenant premises in the Building (but not electricity costs for common areas of the Building) shall be excluded from the definition of Operating Expenses when calculating Tenant's Pro Rata Share of Operating Expenses with respect to the Fourth Floor Premises.

7. Additional Rent for Operating Expenses and Taxes; Increase in Pro Rata Share.

A. As a result of the addition of the Expansion Space to the Premises, effective on the Expansion Space Rent Commencement Date, Section 3(G) of the Original Lease shall be amended and restated in its entirety as follows:

(G) Pro Rata Share. Tenant's pro rata share is 21.04% ("Pro Rata Share").

B. Before the Expansion Space Rent Commencement Date, Tenant shall continue to pay its Pro Rata Share of Taxes and Operating Expenses in accordance with the Original Lease.

C. Commencing on the Expansion Space Rent Commencement Date and continuing until December 31, 2014, Tenant shall pay its Pro Rata Share of Taxes and Operating Expenses in accordance with the Original Lease, except that the Pro Rata Share shall be 21.04%; provided, however, that with respect to the Expansion Space only, the Tax Base shall be the Taxes incurred in calendar year 2013, and the Opex Base shall be Operating Expenses incurred in calendar year 2013.

D. There shall be no payment due for Tenant's Pro Rata Share of Taxes and Operating Expenses for calendar year 2015.

E. Commencing on January 1, 2016 and continuing for the remainder of the Lease Term, Tenant shall pay its Pro Rata Share of Taxes and Operating Expenses in accordance

with the Original Lease, except that (i) the Pro Rata Share shall be 21.04%, and (ii) the Tax Base shall be the Taxes incurred in calendar year 2015, and (iii) the Opex Base shall be Operating Expenses incurred in calendar year 2015.

E. This Section applies only to the Additional Rent due with respect to the Fourth Floor Premises. Tenant's share of Operating Expenses and Taxes for Suite 360 shall continue to be payable pursuant to the First Amendment, as provided in Section 10 below.

8. Advance Rent. Simultaneously with the execution of this Amendment, Tenant shall pay Landlord advance rent in the amount of $18,807.82 (the "Advance Rent"). The Advance Rent shall serve as an additional Security Deposit under the Lease until the Expansion Space Rent Commencement Date, at which time it shall be applied against the first monthly installment of Fourth Floor Premises Base Rent due hereunder.

9. Increase in Security Deposit. Within three (3) business days after the date hereof, the existing Security Deposit of $30,000.00 (which is in the form of a letter of credit) shall be increased in the amount of $94,039.10 (the "Additional Security Deposit") for a total Security Deposit of $124,039.10 to be held by Landlord for the remainder of the Lease Term (as extended by this Amendment) pursuant to Section 3(F) of the Original Lease. The Additional Security Deposit shall be provided in the form of a letter of credit from a financial institution and in a form satisfactory to Landlord. Notwithstanding the foregoing, the Security Deposit shall be reduced to $60,000.00 if no Event of Default has occurred within the first three (3) months of the first Expansion Space Lease Year. To accomplish this reduction, Tenant shall provide Landlord with an amendment to the then-existing letter of credit or a replacement letter of credit, in exchange for which Landlord will surrender to Tenant the letter of credit(s) it is holding as the Security Deposit.

10. Termination of Lease for Suite 360.

A. Notwithstanding anything to the contrary in this Amendment, the Lease with respect to Suite 360 shall terminate on the Original Lease Expiration Date, as provided in the First Amendment, whereupon Tenant shall surrender Suite 360 to Landlord in the condition required by the Amended Lease. Until the Original Lease Expiration Date, Tenant shall continue to pay base rent and additional rent with respect to Suite 360 (and may utilize Suite 360) as provided in the First Amendment.

B. Upon Tenant's request, Landlord shall work with Tenant in good faith to assist Tenant in subleasing some or all of Suite 360, or in securing a new tenant for Suite 360 with whom Landlord would enter into a new prime lease (thereby nullifying the Lease with respect to Suite 360); provided, however, that the terms any such new prime lease must be acceptable to Landlord in its sole and absolute discretion.

C. Section 7 of the First Amendment (entitled "Renewal Options") is hereby deleted and shall be of no further force or effect.

11. Deletion of Existing Renewal Option. Section 43 of the Original Lease (entitled "Renewal Option") is hereby deleted and shall be of no further force or effect, it being understood that Tenant's sole renewal option shall be as set forth in Section 12 below.

12. Renewal Option.

A. Provided that (i) both at the time of the exercise of the option hereinafter set forth and at the time of commencement of the "Renewal Term" (as defined below) the Lease is in full force and effect and provided further that Tenant is not then in default hereunder beyond the expiration of any applicable notice and cure period provided for the Lease, and (ii) Tenant and/or a Permitted Transferee (as defined below) is in occupancy of the entire Fourth Floor Premises for the purpose of conducting its own business, Tenant is hereby granted the option to renew the Lease Term for one (1) additional period of ten (10) Lease Years (the "Renewal Term"), such Renewal Term to commence at the expiration of the initial Lease Term. Tenant shall exercise its option to renew by delivering written notice of such election (the "Renewal Notice") to Landlord not less than eleven (11) months prior to the expiration of the Lease Term. Tenant's exercise of its option to renew pursuant to the Renewal Notice shall be irrevocable. In the event that Landlord does not receive the Renewal Notice prior to the expiration of such time period (time being of the essence with respect thereto), then such option to renew the Lease Term shall, upon the expiration of such time period, become null and void and be of no further force or effect, and Tenant shall, at the request of Landlord, execute an instrument in form and substance acceptable to Landlord confirming such facts.

B. The Renewal Term shall be upon the same terms and conditions of the Lease, except that, subject to subsection C below, the Rent during the Renewal Term shall be at an annual rate equal to one hundred percent (100%) of the then current fair market rental rate for comparable space in buildings in the Bethesda/Chevy Chase sub-market comparable to the Premises in the Property, taking into account market concessions offered at such time for renewal space (the "FMR"); provided, however, that in lieu of the FMR, the Rent during the Renewal Term may be determined by Landlord and Tenant by mutual agreement; however, if Landlord and Tenant cannot agree in writing on the FMR within ten (10) days after Tenant's notice of its election to renew, the FMR shall be determined by the Three Broker Method set forth below. Tenant shall have no option to renew the Lease beyond the expiration of the Renewal Term, and the Premises shall be delivered to Tenant in their existing condition (on an "as is" basis) at the time the Renewal Term commences.

C. Notwithstanding anything to the contrary in this Section, in lieu of determining the Rent in accordance with the FMR, Tenant may elect to pay $668,320.40 as Fourth Floor Premises Base Rent for the first Lease Year of the Renewal Term, with such Rent escalating annually by 2.75% at the commencement of each new Lease Year. This election must be made, if at all, at the time Tenant delivers its Renewal Notice, time being of the essence.

D. The "Three Broker Method" shall operate as follows: The FMR shall be based upon one hundred percent (100%) of the current fair market rental rate for comparable space in comparable buildings in the Bethesda/Chevy Chase area, taking into account market concessions offered at such time for renewal space, which shall be determined by a board of three

(3) licensed real estate brokers, one of whom shall be named by Landlord, one by Tenant, and the two so appointed shall select a third broker. Each member of the board shall be licensed in Maryland as a real estate broker, specializing in the field of commercial office leasing in the Bethesda/Chevy Chase area of Maryland, having no less than ten (10) years' experience in such field, and recognized as ethical and reputable within the field. Landlord and Tenant agree to make their appointments with five (5) days after Landlord and Tenant are unable to agree upon the FMR. The two (2) brokers selected by Landlord and Tenant shall select the third broker within ten (10) days after they both have been appointed, and each broker, within fifteen (15) days after the third broker is elected, shall submit his or her determination of the FMR. The FMR shall be the determination of the broker that is not the highest or the lowest (or, if two brokers reach an identical determination, the determination of such two brokers). Landlord and Tenant shall each pay the fee of the brokers selected by it, and they shall equally share the payment of the fee of the third broker.

E. The FMR shall be the Rent with respect to the Premises during the first year of the Renewal Term and shall thereafter escalate on each subsequent anniversary of the commencement of the Renewal Term during the remainder of the Renewal Term at 2.75% per annum over the prior year's Rent.

F. Notwithstanding anything to the contrary contained above, if Tenant is dissatisfied with the FMR, as determined by the Three Broker Method, then Tenant may withdraw its renewal option upon written notice to Landlord, provided such notice is given within ten (10) days after being notified of the FMR, as determined by the Three Broker Method, and at least nine (9) months before the expiration of the Lease Term, time being of the essence. If Tenant timely withdraws its renewal option, the Lease shall terminate at the expiration of thirteenth Expansion Space Lease Year, as if Tenant had never exercised its renewal option. If Tenant so withdraws its renewal option, Tenant shall pay or shall reimburse Landlord for any and all of Landlord's costs incurred in connection with the renewal option, including all fees of the brokers selected to compute the FMR and Landlord's reasonable attorney's fees.

13. Renovation of Building Lobby. Before the end of the first Expansion Space Lease Year, Landlord shall redesign and renovate the lobby of the Building as determined by Landlord in its sole and absolute discretion. All aspects of this renovation, including, without limitation, the design, materials, specifications, finishes, contractor, and construction schedule, shall be determined by Landlord in its sole and absolute discretion.

14. Deletion of Option to Terminate. Section 44 of the Original Lease (entitled "Option to Terminate") is hereby deleted and shall be of no further force or effect.

15. Deletion of Right of First Offer. Section 45 of the Original Lease (entitled "Right of First Offer") is hereby deleted and shall be of no further force or effect.

16. Deletion of Landlord's Lien. Section 39 of the Original Lease (entitled "Landlord's Lien") is hereby deleted and shall be of no further force or effect.

17. Landlord's Waiver. Landlord agrees, within fifteen (15) days after written request of Tenant, from time to time, to execute a Landlord's Waiver or similar document in such form as may be reasonably requested by any institutional lender making a loan to Tenant in connection with Tenant's Expansion Space Work, any equipment or medical devices to be installed in the Premises, any refinancing of any such loan or any other loan from an institutional lender to Tenant for Tenant's legitimate business purposes, by which Landlord shall waive its lien rights in any collateral for such loan and containing such other reasonable and customary terms as any such lender may request.

18. Reserved Parking.

A. In addition to the parking that Tenant is entitled to under the terms of the Amended Lease, Landlord grants to Tenant the right to exclusive use of the six (6) parking spaces (the "Reserved Spaces") located on the surface in the parking lot in front of the Building currently designated as "30 minute parking," which spaces were previously the subject of a Parking Space Rental Agreement by and between Landlord and Tenant dated March 1, 2005 (the "Parking Space Agreement"). Tenant agrees to pay an initial parking rental fee, effective the date of this Amendment of $120 per month for each of the Reserved Spaces, which fee shall be payable monthly in advance on or before the first day of each month. Effective January 1, 2013 and the first day of each subsequent year during the Lease Term, Landlord may adjust such fee to the then market rental rate as reasonably established by Landlord. Tenant may terminate its right to use (and obligation to pay for) any one or more of the Reserved Spaces upon thirty (30) days prior written notice to Landlord, from time to time during the Lease Term. Landlord and Tenant agree that the Parking Space Agreement is hereby terminated.

B. All motor vehicles (including all contents thereof) shall be parked in the Reserved Spaces at the sole risk of the owner thereof, it being expressly agreed and understood that Landlord has no duty to insure any of said motor vehicles (including the contents thereof), and that Landlord is not responsible for the protection and/or security of such vehicles. Landlord shall have no liability whatsoever to Tenant with respect to any property damage and/or personal injury that occurs as a result of or in connection with the parking of said motor vehicles in any of the Reserved Spaces, and Tenant hereby agrees to indemnify and hold Landlord harmless from and against any and all costs, claims, expenses, and/or causes of action (including reasonable attorney's fees) which Landlord may incur in connection with or arising out of Tenant's use of the Reserved Spaces.

C. It is further agreed that the Lease shall not be deemed to create a bailment between the parties hereto, it being expressly agreed and understood that the only relationship created between Landlord and Tenant hereby is that of Landlord and Tenant, respectively.

D. In its use of the Reserved Spaces, Tenant shall follow all of the rules of the Building applicable thereto, as the same may be reasonably amended from time to time. Upon the occurrence of any breach of such rules, or default by Tenant under this Lease, Landlord will notify Tenant of said breach. If after thirty (30) days Tenant has not corrected said breach or default, then Landlord shall be entitled to terminate Tenant's right to exclusive use of the Reserved Spaces.

E. In the event of substantial casualty damage to the parking lot (the "Building Parking Lot") which makes it impossible or impractical for Landlord economically to comply with the Lease as it relates to the Reserved Spaces, Tenant's right to the exclusive use of the Reserved Spaces shall terminate upon and as of the date of such casualty. If the Building Parking Lot (or a portion thereof) or any part of the real property upon which the Lot is situated is taken by a governmental body or a sale in lieu thereof or otherwise made impossible for Landlord economically to comply with the Lease, Tenant's right to exclusive use of the Reserved Spaces shall terminate as of the date of such taking or sale.

F. The Reserved Spaces are specifically designated for patients visiting the office of Massachusetts Avenue Surgery Center ("MASC") and employees of MASC. There will be signs constructed and maintained by Landlord, at Tenant's cost, that authorize only patients or employees of MASC to park in these spaces.

19. Notice to Tenant's Attorney. Any notice of default, breach or of a similar character sent to Tenant under or in connection with the Lease shall be accompanied by a copy of such notice sent by the same method to Tenant's counsel, John J. Eller, Esq., Ober, Kaler, Grimes & Shriver, a Professional Corporation, 100 Light Street, Baltimore, Maryland 21202.

20. Assignment and Subletting—Permitted Transfers. Notwithstanding anything to the contrary contained in the Original Lease, Tenant shall have the right, without Landlord's consent, from time to time, to assign, sublet or otherwise permit the use or occupancy of the Premises or any part thereof, in whole or in part (a "Transfer") to or by any Permitted Transferee. Tenant shall promptly notify Landlord if it enters into any Transfer with any Permitted Transferee. As used herein, a Permitted Transferee is (i) any affiliate of Tenant, (ii) any entity resulting from a merger or consolidation of Tenant, so long as such entity has a net worth equal to or greater than the net worth of Tenant as of the date of this Amendment, or (iii) any entity purchasing all or substantially all of the assets of Tenant, so long as such entity has a net worth equal to or greater than the net worth of Tenant as of the date of this Amendment. Without limiting the generality of the forgoing, Sections 12 (A), 12 (B), 12 (C) (1), and 12 (C) (4) of the Original Lease shall not apply to any Transfer to a Permitted Transferee. No such Transfer to a Permitted Transferee shall relieve Tenant of any liability under the Lease.

21. Assignment and Subletting—Section 12(D). Section 12(D) of the Original Lease is hereby deleted and the following substituted in its place:

> (D) The following events shall constitute an "Assignment," which is subject to the terms of this Section, and for which Landlord's prior written consent (not to be unreasonably withheld, conditioned or delayed) is required: (i) if Tenant is a corporation, and fifty-one percent (51%) or more of Tenant's shares of stock are transferred by sale, assignment or other conveyance in related transactions to one or more parties; (ii) if Tenant is a partnership and fifty-one percent (51%) or more of any general partnership interest(s) is transferred by sale, assignment or other conveyance in related transactions to one or more parties; and (iii) if Tenant is a limited liability company or any other type of entity, and fifty-one percent (51%) or more of the membership or other ownership interests are

transferred by sale, assignment or other conveyance in related transactions to one or more parties. The intent of this provision is to apply only to a single transaction (or series of related transactions) that result in the change in control of Tenant, and not to apply to isolated changes in the ownership of Tenant as the result, for example, of the admission of new doctors to Tenant's practice or the retirement or resignation of existing doctors. Moreover, notwithstanding the foregoing, this Section shall not apply to the transfer of a controlling interest in Tenant to a hospital or other entity operating a medical clinic or medical facility.

22. Non-Disturbance. Notwithstanding anything to the contrary contained in the Original Lease: (i) as a precondition to the Lease and Tenant's rights thereunder being subject and subordinate to the lien of any mortgage upon the Property or Premises, Landlord shall obtain for the benefit of Tenant a non-disturbance agreement (a "Non-Disturbance Agreement"), reasonably satisfactory to Tenant, which provides that, so long as Tenant is not in default of its obligations under the Lease beyond the expiration of any applicable grace or cure period, in the event of any foreclosure, deed in lieu of foreclosure, termination of any land lease or similar conveyance, the Lease shall not be terminated, nor shall Tenant's right to occupy the Premises be affected, and, so long as Tenant observes and performs all of the obligations of Tenant to be performed pursuant to the Lease, the mortgagee will perform all obligations of Landlord required to be performed under the Lease (subject to reasonable and customary exceptions as provided in the Non-Disturbance Agreement), and (ii) Landlord shall use its best efforts to obtain from the holder of any mortgage, deed of trust, land lease or similar instrument affecting the Property or the Premises on the date of this Amendment, a Non-Disturbance Agreement, reasonably satisfactory to Tenant, within twenty (20) days after the date of execution of this Amendment. The third sentence of Section 16 of the Original Lease (providing Landlord with a power of attorney to execute subordination documents on Tenant's behalf) is hereby deleted.

23. Default Provisions.

A. Notwithstanding the provisions of Section 22(A)(1) of the Original Lease, failure to make payment of any Rent, Additional Rent, or any other payment required to be made by Tenant under the Lease shall not be an Event of Default unless Landlord has given Tenant written notice of such failure and Tenant fails to make payment in full within five (5) days after the giving of written notice; provided, however, that Landlord shall only be required to give such written notice one (1) time in any twenty-four (24) month period, and, if Landlord has given such written notice one (1) time in any twenty-four (24) month period, then any failure of Tenant to make such payment, if it shall continue for a period of five (5) days, shall constitute an Event of Default; provided, further, that if such failure occurs a second time during a twenty-four (24) month period, then, for such second failure only, Landlord will provide Tenant with notice by phone, email or letter, and if such failure continues for forty-eight (48) business hours thereafter, such failure shall constitute an Event of Default.

B. Notwithstanding the provisions of Section 22(A)(8) of the Original Lease, the failure by Tenant to furnish to Landlord any statement required by the Lease within ten (10) days after its due date shall not constitute an Event of Default unless such failure continues for five (5) additional days after Landlord sends Tenant a second written notice stating that failure to

supply such statement shall constitute an Event of Default if such statement is not supplied within five (5) days after Landlord's second notice.

C. Section 22(D) of the Original Lease is hereby deleted and the following substituted in its place:

> (D) Notwithstanding any other provision of this Section 22, Tenant shall have a period of fifteen (15) days after notice thereof to cure, to the reasonable satisfaction of Landlord, any Event of Default not involving a payment of Rent or Additional Rent or any other payment due hereunder; provided, however, if such non-monetary Event of Default is not reasonably susceptible of cure within such fifteen (15) day period, then no Event of Default shall occur as long as Tenant commences cure within such fifteen (15) day period, and thereafter diligently and continuously pursues the cure to completion within a reasonable period of time.

24. Holdover. Clause (i) in Section 21(A) is hereby deleted and the following substituted in its place:

> (i) renewal of this Lease for three (3) months, and from three (3) months to three (3) months thereafter; provided, however, that if Tenant surrenders possession of the Premises to Landlord in the condition required by the Lease on or before the end of any such 3-month holdover period, then the Lease Term shall terminate on the last day of such 3-month holdover period,

25. Signage. Tenant acknowledges that ACG has primary rights to signage on the exterior of the Building. However, Landlord will work in good faith to assist Tenant in Tenant's efforts to obtain additional signage, provided Tenant reimburses Landlord for any reasonable costs incurred in providing such assistance. Any such additional signage shall be subject to (i) governmental codes and regulations, (ii) Landlord's prior written approval, which shall not be unreasonably withheld, conditioned or delayed, and (iii) ACG's approval, if such approval is required under ACG's lease.

26. Broker Commission. Landlord and Tenant each warrant and represent to the other that, except for Prestige Properties Intl LLC ("Prestige Properties"), acting on behalf of Tenant, no broker brought about this transaction or dealt with either party in connection herewith. Landlord and Tenant shall indemnify and hold harmless the other from and against any claim for brokerage fees or other commissions arising from such party having employed a broker (other than Prestige Properties) contrary to its representation in this Section. Landlord shall pay any commissions or fees that are payable to Prestige Properties with respect to this transaction, in accordance with the provisions of a separate agreement.

27. No Setoffs. All rent payable under this Amendment (as well as all other rent payable under the Lease) shall be payable by Tenant without demand and without setoff, recoupment, or other reduction, except as otherwise provided in the Lease.

28. Capitalized Terms. All capitalized terms in this Amendment shall have the same meanings as in the Amended Lease unless expressly provided otherwise herein.

29. Ratified and Confirmed. The Amended Lease, as amended by this Amendment, is hereby ratified and confirmed. To the extent of any inconsistency between this Amendment and the Amended Lease, this Amendment will govern.

IN WITNESS WHEREOF, the parties have caused this Amendment to be executed under seal as of the date above written.

LANDLORD:

WITNESS:

6400 GOLDSBORO, LLC,
a Delaware limited liability company

By: [signature]
Title: Authorized Person

Title:____________________

TENANT:

WITNESS:

MASSACHUSETTS AVENUE SURGERY CENTER, LLC,
a Maryland limited liability company

[signature]
Title: Director of Operations

By: [signature]
Title: Chairman of Board

[Corporate Seal]

List of Exhibits:

Exhibit A – Outline of the Expansion Space
Exhibit B – Expansion Space Declaration
Exhibit C – Approved Space Plan

**EXHIBIT B**

EXPANSION SPACE DECLARATION

THIS EXPANSION SPACE DECLARATION (this "Declaration") is made this __ day of ________, 2012 by and between 6400 Goldsboro, LLC ("Landlord") and Massachusetts Avenue Surgery Center, LLC ("Tenant").

Landlord and Tenant are parties to a Lease Agreement dated June 1, 2004 (the "Original Lease"), as amended by a First Amendment to Lease dated September 8, 2008 (the First Amendment"), as amended by a Second Amendment to Lease dated December __, 2011 (the "Second Amendment") with respect to Premises in an office building located at 6400 Goldsboro Road, Bethesda, Maryland 20817. (The Original Lease, as amended by the First Amendment and Second Amendment is referred to hereafter collectively as the "Lease.")

All capitalized terms used herein shall have the same meaning as was ascribed to such terms in the Lease. This Declaration is being executed pursuant to the Second Amendment with respect to the Expansion Space.

Landlord and Tenant herby declare as follows:

(a) the Expansion Space Commencement Date is April 2, 2012;

(b) the Expansion Space Rent Commencement Date is August 2, 2012; and

(c) unless sooner terminated pursuant to the Lease, the Lease Term shall end on __________, _____, which is the Fourth Floor Lease Expiration Date, and which also is the last day of the thirteenth (13th) Expansion Space Lease Year.

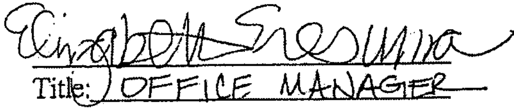
[Signatures on next page.]

IN WITNESS WHEREOF Landlord and Tenant have executed this Declaration under seal as of the date above written.

LANDLORD:

WITNESS:

6400 GOLDSBORO, LLC,
a Delaware limited liability company



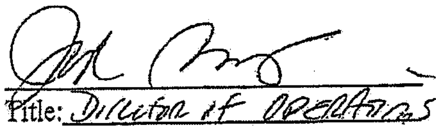
Title: OFFICE MANAGER

By: ____________________ (Seal)
Title: ____________________

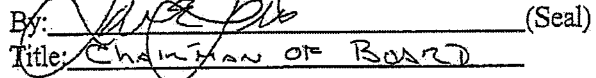
TENANT:

WITNESS:

MASSACHUSETTS AVENUE SURGERY CENTER, LLC,
a Maryland limited liability company



Title: Director of Operations



By: ____________________ (Seal)
Title: Chairman of Board

[Corporate Seal]

IN WITNESS WHEREOF Landlord and Tenant have executed this Declaration under seal as of the date above written.

LANDLORD:

WITNESS:

6400 GOLDSBORO, LLC,
a Delaware limited liability company

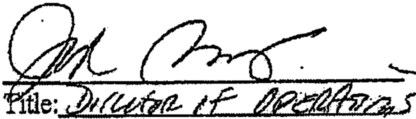
By: ______________________(Seal)
Title: ______________________

Title: ______________________

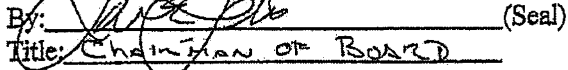
TENANT:

WITNESS:

MASSACHUSETTS AVENUE SURGERY CENTER, LLC,
a Maryland limited liability company



Title: Director of Operations



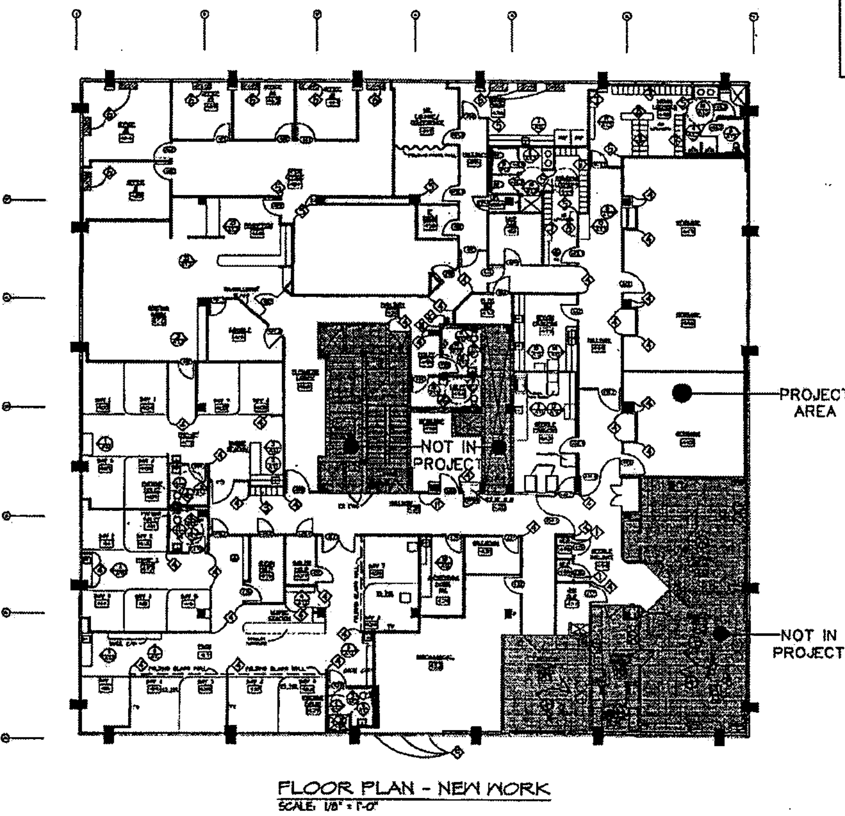
By: ______________________(Seal)
Title: Chairman of Board

[Corporate Seal]

## EXHIBIT A

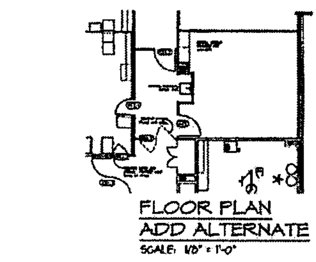
(Outline of Expansion Space)

Exh A




FLOOR PLAN - NEW WORK

SCALE: 1/8" = 1'-0"



FLOOR PLAN
ADD ALTERNATE

SCALE: 1/8" = 1'-0"

PARTITION GRAPHIC:

NEW PARTITIONS

EXISTING PARTITIONS

GENERAL NOTES:

1. CONTRACTOR TO FAMILIARIZE THEMSELVES WITH THE SCOPE OF WORK & TO IMMEDIATELY NOTIFY THE ARCHITECT WITH ANY DISCREPANCIES.
2. GENERAL CONTRACTOR TO COORDINATE WITH SPRINKLER CONTRACTOR SPRINKLER HEAD LOCATIONS TO COMPLY WITH CURRENT APPLICABLE CODES.
3. SEE DRAWING A3.1 FOR LAYOUT DIMENSIONS & PARTITION TYPES.

FLOOR PLAN - NEW WORK NOTES:

1. Provide 5 adj shelves
2. Reinstall ex equip
3. Reinstall ex lockers
4. Corner guard CG-1
5. Corner guard CG-2
6. New PTAC, see Mechanical dwgs
7. New lockers
8. New locker bench
9. New louvers in ex opening, match ex
10. New EMC, see Mechanical dwgs
11. New fire extinguisher cabinet

KMD Architects, LLC

106 Rosewood Drive
Greenbelt, MD 20770
301-787-2380
ken@kmdarchitects.net

Leach Wallace Associates, Inc

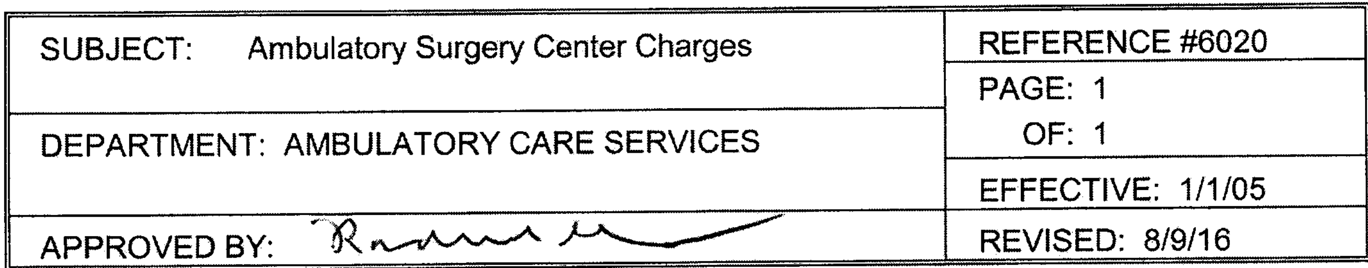
MASSACHUSETTS AVENUE SURGERY CENTER

MASSACHUSETTS AVENUE
SURGERY CENTER
EXPANSION & RENOVATION

FLOOR PLAN - NEW WORK

A4.1

# Exhibit 14.
# Policy on Information on Charges



| SUBJECT: Ambulatory Surgery Center Charges | REFERENCE #6020 |
| --- | --- |
| | PAGE: 1 OF: 1 |
| DEPARTMENT: AMBULATORY CARE SERVICES | EFFECTIVE: 1/1/05 |
| APPROVED BY: [signature] | REVISED: 8/9/16 |

**POLICY:**

It is the policy of The Massachusetts Avenue Surgery Center (MASC) to make available to any current or potential future patients their estimated charges, expected allowable and estimated out of pocket expenses for their outpatient procedure.

**PROCEDURE:**

- All patient's primary insurance will be verified, by MASC's intake department, with respect to coverage and benefits based on the intake sheet provided by the surgeon's office. The scheduling department will then calculate the patients total estimated out of pocket expenses for any co-insurance and record this information on the patient's face sheet so that the pre-op nurse can discuss with the patient prior to their date of service. The scheduling department will contact the patient prior to their date of service to determine if there is any unmet annual deductible or per surgery co-pays that needs to be collected at time of service.

- All patients coming to MASC on a self-pay basis are supplied with their fees in advance of their surgeries. MASC collects all self-pay fees at the time of the surgery.

All public inquiries about MASC fees are directed to the Scheduling Department or Executive Director for discussion and disclosure.

Exhibit 15.
DHHS Office of the Inspector General Study

# Department of Health and Human Services

## OFFICE OF INSPECTOR GENERAL

# MEDICARE AND BENEFICIARIES COULD SAVE BILLIONS IF CMS REDUCES HOSPITAL OUTPATIENT DEPARTMENT PAYMENT RATES FOR AMBULATORY SURGICAL CENTER-APPROVED PROCEDURES TO AMBULATORY SURGICAL CENTER PAYMENT RATES

*Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.*

Daniel R. Levinson
Inspector General

April 2014
A-05-12-00020

# *Office of Inspector General*

https://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

## *Office of Audit Services*

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

## *Office of Evaluation and Inspections*

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

## *Office of Investigations*

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

## *Office of Counsel to the Inspector General*

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

# *Notices*

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**THIS REPORT IS AVAILABLE TO THE PUBLIC**
at https://oig.hhs.gov

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

**OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS**

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

## EXECUTIVE SUMMARY

***Medicare and beneficiaries could save billions if the Centers for Medicare & Medicaid Services reduces hospital outpatient department payment rates for ambulatory surgical center-approved procedures to the same level as ambulatory surgical center payment rates.***

### WHY WE DID THIS REVIEW

Medicare covers many outpatient surgical procedures commonly performed in both hospital outpatient departments (outpatient departments) and in ambulatory surgical centers (ASCs). Medicare ASC payment rates are frequently lower than outpatient department payment rates. Thus, Medicare generally saves when outpatient surgical procedures that do not pose significant risk to patients are performed in an ASC instead of an outpatient department. Our review quantifies the impact of this payment differential on aggregate Medicare expenditures for outpatient surgical procedures in the ASC setting as compared with outpatient departments. We completed this review in response to a congressional request, which asked us to assess the impact on total Medicare expenditures of providing surgical services in an ASC as opposed to other outpatient settings.

Our objectives were to determine how much Medicare (1) has saved as a result of procedures being performed in ASCs instead of outpatient departments and (2) could save if payment rates for the outpatient departments were reduced to the same level as ASC payment rates.

### BACKGROUND

In 1982, Medicare began covering services provided in ASCs because the Centers for Medicare & Medicaid Services (CMS) recognized that some surgical services provided on an inpatient basis could be safely performed in less intensive and less costly settings, such as ASCs and outpatient departments. ASC prospective payment system (ASCPPS) rates are frequently lower than outpatient prospective payment system (OPPS) rates, resulting in savings for Medicare.

Both the OPPS and ASCPPS must be budget neutral. Congress incorporated budget neutrality into these payment systems to ensure that total Medicare payments would not increase or decrease because of fluctuations within the systems themselves, other than the yearly adjustment for inflation.

### WHAT WE FOUND

Medicare saved almost $7 billion during calendar years (CYs) 2007 through 2011 and could potentially save $12 billion from CYs 2012 through 2017 because ASC rates are frequently lower than outpatient department rates for surgical procedures. In addition, Medicare could generate savings of as much as $15 billion for CYs 2012 through 2017 if CMS reduces outpatient department payment rates for ASC-approved procedures to ASC payment levels for procedures performed on beneficiaries with low-risk and no-risk clinical needs.

Beneficiaries would also save through reduced cost sharing. Beneficiaries saved approximately $2 billion during CYs 2007 through 2011 and could potentially save an additional $3 billion for the next 6 years because the ASC rates are frequently lower than outpatient department rates. In addition, beneficiaries could potentially save as much as $2 billion to $4 billion more during the 6 years through CY 2017 if CMS reduces outpatient department payment rates for ASC-approved procedures to ASC payment levels.

We recognize that not all procedures can be performed in an ASC because a procedure might pose a significant safety risk to the patient. To account for this, we obtained patient-risk statistics from the Agency for Healthcare Research and Quality. The risk statistics showed that 33 percent of hospital patients 65 and older were considered to have no-risk medical profiles and an additional 35 percent were considered to be at low risk for procedures performed at an ASC. In total, 68 percent of patients had either low- or no-risk medical profiles. We used these risk profiles to estimate the range of potential savings to be between $7 billion and $15 billion for Medicare for CYs 2012 through 2017.

## WHAT WE RECOMMEND

We recommend that CMS:

- seek legislation that would exempt the reduced expenditures as a result of lower OPPS payment rates from budget neutrality adjustments for ASC-approved procedures.

If Congress passes the budget-neutrality exemption for the reduced expenditures, we recommend that CMS take the following actions, which we estimated could save as much as $15 billion from CYs 2012 through 2017:

- reduce OPPS payment rates for ASC-approved procedures on beneficiaries with no-risk or low-risk clinical needs in outpatient departments and then

- develop and implement a payment strategy in which outpatient departments would continue to receive the standard OPPS payment rate for ASC-approved procedures that must be provided in an outpatient department because of a beneficiary's individual clinical needs.

## CMS COMMENTS AND OUR RESPONSE

In written comments on our draft report, CMS did not concur with our recommendations. CMS stated that adopting the recommendations would require legislation and that such a proposal is not currently included in the President's Budget. CMS also noted that the recommended changes "…may raise circularity concerns with respect to the rate calculation process" because most ASC payment rates are based on the OPPS payment rates that we are recommending that CMS reduce and that we did not provide specific clinical criteria to distinguish patients' risk levels.

We continue to recommend that CMS draft, and submit for review, a legislative proposal that would exempt the reduced expenditures as a result of lower OPPS payment rates from budget

neutrality adjustments for consideration for inclusion in future budget and legislative agendas. As part of the process for developing the President's Budget, CMS identifies program vulnerabilities and offers solutions for addressing them. CMS has the authority to develop legislative proposals for Medicare and has historically addressed some OIG recommendations to seek legislative change by developing legislative proposals for possible inclusion in the President's budget and legislative program. Safeguarding programs from fraud, waste, and abuse is an ongoing program management responsibility and some issues may require legislation to address. We look forward to CMS's final management decision in light of this clarification of the intent of our recommendations.

Also, we agree that we did not provide specific clinical criteria to distinguish patients' risk levels and that, depending on the method used to implement our recommendations, circularity concerns may arise. However, that does not prevent implementation of our recommendations. CMS is in the best position to determine how to assess a patient's risk and to develop a payment strategy that would reduce OPPS payments for no- and low-risk patients without disrupting the current payment methodologies. Considering the potential savings identified in our report, we maintain that CMS should take the necessary steps to implement our recommendations.

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# INTRODUCTION

## WHY WE DID THIS REVIEW

Medicare covers many outpatient surgical procedures commonly performed in both hospital outpatient departments (outpatient departments) and in ambulatory surgical centers (ASCs). Medicare ASC payment rates are frequently lower than outpatient department payment rates. Thus Medicare generally saves when outpatient surgical procedures that do not pose significant risk to patients are performed in an ASC instead of an outpatient department. Our review quantifies the impact of this payment differential on aggregate Medicare expenditures for outpatient surgical procedures in the ASC setting as compared with outpatient departments. We completed this review in response to a congressional request, which asked us to assess the impact on total Medicare expenditures of providing surgical services in an ASC as opposed to other outpatient settings.

## OBJECTIVES

Our objectives were to determine how much Medicare (1) has saved as a result of procedures being performed in ASCs instead of outpatient departments and (2) could save if payment rates for the outpatient departments were reduced to the same level as ASC payment rates.

## BACKGROUND

### How the Hospital Outpatient Prospective Payment System Works

Medicare beneficiaries receive a wide range of services in outpatient departments, from injections to complex procedures that require anesthesia. With changes in technology and medical practices, services traditionally provided in inpatient settings are more frequently provided in outpatient settings such as outpatient departments. In 2011, approximately 4,800 hospitals nationwide provided inpatient and outpatient services reimbursed by Medicare.

The Centers for Medicare & Medicaid Services (CMS) uses the hospital Outpatient Prospective Payment System (OPPS) to pay outpatient departments for designated Medicare Part B services furnished to hospital outpatients.[1] The services are identified by Healthcare Common Procedure Coding System (HCPCS) codes. CMS classifies services into ambulatory payment classifications (APCs) on the basis of clinical and resource use similarity. All services in an APC have the same payment rate.

CMS determines the payment rate for each outpatient department service by multiplying the relative weight for the service's APC by an OPPS conversion factor. The relative weight for an APC measures the resource requirements of the service and is based on the median cost of services and procedures in that APC. The purpose of the conversion factor is to translate relative weights into dollar amounts. The OPPS conversion factor is updated annually for inflation using

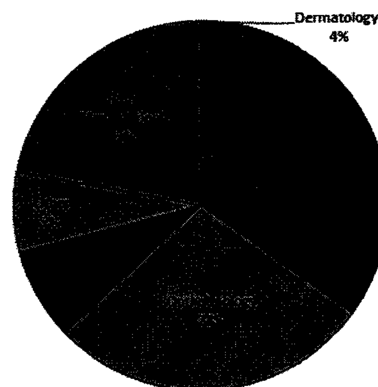
[1] 42 CFR § 419.2(a). See also, Social Security Act (the Act), §§ 1833(t)(1)(A) and (t)(1)(B)(i).

the hospital market basket price index (HMB).[2] In addition, the OPPS conversion factor is reduced by the Multifactor Productivity (MFP)[3] adjustment for 2012 and subsequent years[4] and by an additional adjustment for 2010 through 2019.[5]

**How CMS Determines Payment Rates for Each Ambulatory Surgical Center Service**

ASCs provide surgical services to patients who do not require an overnight stay. In 1982, Medicare began covering services provided in ASCs because CMS recognized that some surgical services provided on an inpatient basis could be safely performed in less intensive and less costly settings. In 2011, there were approximately 5,300 Medicare-certified ASCs nationwide. The most common types of surgical services performed in ASCs are presented in Figure 1.[6]

**Figure 1: Medicare Case Volume by Specialty 2010**




The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) required CMS to implement a revised ASC payment system. As a result, effective January 1, 2008, CMS implemented the ASC Prospective Payment System (ASCPPS) based on the OPPS, as recommended in the Government Accountability Office (GAO) report mandated by Congress.[7] The revised ASCPPS rate setting methodology continued to result in ASC payment rates that were frequently less than OPPS payment rates for the same procedure. With certain exceptions, the calendar year (CY) 2008 ASC payment rates were about 67 percent of the corresponding OPPS payment rates, which reflects the lower cost of furnishing services in the ASC setting.

CMS determines the payment rate for each ASC service by multiplying the relative weight for the service's APC by the ASC conversion factor (adjusted for geographic differences). The APC

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[2] CMS defines a market basket as a fixed-weight index that "answers the question of how much more or less it would cost, at a later time, to purchase the same mix of goods and services that was purchased in a base period" (55 Fed. Reg. 35990, 36044 (Sept. 4, 1990)). Individual market baskets are produced for many of the Medicare payment systems to accurately measure anticipated price changes. The HMB index for 2012 was 3 percent (76 Fed. Reg. 74122, 74189 (Nov. 30, 2011)).

[3] The MFP is an adjustment to the price index that reflects a change in productivity (output) that cannot be accounted for by the change in inputs.

[4] The OPPS MFP adjustment for 2012 was 1 percent (76 Fed. Reg. 74122, 74189 (Nov. 30, 2011)).

[5] The additional adjustment for 2012 was 0.1 percent (the Act, §§1833(t)(3)(F)(ii) and (t)(3)(G)(ii)). See also, 42 CFR § 419.32(b)(1)(iv)(B)(3).

[6] ASC Association, *Ambulatory Surgery Centers: A Positive Trend in Health Care*, October 8, 2011.

[7] GAO, *Payment for Ambulatory Surgical Centers Should Be Based on the Hospital Outpatient Payment System* (GAO-07-86), November 2006.

relative weights for most procedures in the ASCPPS are the same as the relative weights in the OPPS. The ASC conversion factor also translates the relative weights into dollar amounts and was originally created as a percentage of the OPPS conversion factor; however, it is updated annually for inflation using the Consumer Price Index for All Urban Consumers[8] (CPI-U) and the ASCPPS MFP adjustment.[9]

### Medicare Payments Must Remain Budget Neutral

Both the OPPS and ASCPPS must be budget neutral (the Act, § 1833). Congress incorporated budget neutrality into these payment systems to ensure that total Medicare payments would not increase because of fluctuations within the systems themselves, other than the yearly adjustment for inflation. Thus, the effects of an increase in the relative weights of some procedures would be offset by a decrease in the relative weights of other procedures.

The MMA required that the revised ASC payment system be budget neutral, similar to the OPPS. That is, the payment rates are intended to ensure that total Medicare expenditures under the revised payment methodology for ASCs will be approximately the same as the expenditures would have been in the same year without the revised ASC payment system.

### Medicare Beneficiaries Share the Financial Responsibility for Procedures Performed

"Beneficiary cost sharing" is the Medicare beneficiary's share of the financial responsibility for the procedure performed. For ASC procedures provided on or after January 1, 2008, the beneficiary pays the lesser of "20 percent of the actual charge or 20 percent of the prospective payment amount . . . ." (42 CFR § 410.152(i)(2)). For procedures provided in outpatient departments, Medicare is transitioning to a standard Medicare 20 percent coinsurance rate by requiring the beneficiary to pay the greater of 20 percent of the APC payment or, for certain services, a set payment amount which cannot exceed 40 percent of the APC payment (42 CFR §§ 419.40–419.42)).[10] When the beneficiary's clinical needs allow for a procedure to be performed in an ASC, the beneficiary could choose to do so and benefit because the payment rates are usually lower than in an outpatient department. If the procedure is performed in an outpatient department, both the Medicare payment and the beneficiary cost-sharing amount are generally higher.

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[8] The Bureau of Labor Statistics' Web site states "the CPI-U represents changes in prices of all goods and services purchased for consumption by urban households" and covers approximately 87 percent of the total population (Bureau of Labor Statistics, *Overview*. – Accessed on July 25, 2013). For the purposes of the ASC conversion factor, the CPI-U for 2012 was 2.7 percent (76 Fed. Reg. 74122, 74450 (Nov. 30, 2011)).

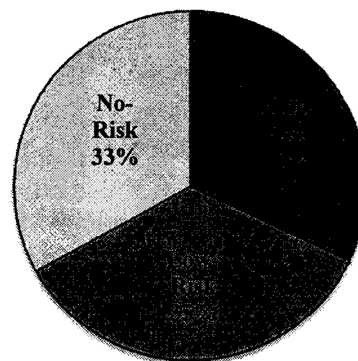
[9] The ASCPPS MFP adjustment for 2012 was 1.1 percent (76 Fed. Reg. 74122, 74450 (Nov. 30, 2011)).

[10] As the total APC payment increases each year, the set payment amount will become a smaller portion of the total payment until it represents 20 percent of the total payment. CMS estimated that, for CY 2013, the overall beneficiary share of total payments for Medicare-covered hospital outpatient services would be about 21.6 percent. (CMS, *Proposed 2013 Policy, Payment Changes for Hospital Outpatient Departments, Ambulatory Surgical Centers, Inpatient Rehabilitat* [sic], fact sheet, July 6, 2012.).

## Ambulatory Surgical Center-Approved Procedures Do Not Pose a Significant Safety Risk to Most Patients

In selecting covered surgical procedures payable under ASCPPS, the Secretary of Health and Human Services (the Secretary) must select only those procedures that "would not be expected to pose a significant safety risk to a Medicare beneficiary when performed in an ASC . . . ." (42 CFR § 416.166(b)). However, "[t]he decision regarding the most appropriate care setting [e.g., an ASC or outpatient department] for a given surgical procedure is made by the physician based on the beneficiary's individual clinical needs and preferences."[11] Accordingly, a physician may determine that a covered procedure cannot be performed in an ASC because of a specific patient's clinical needs. To account for these procedures in our report, we obtained statistics from the Agency for Healthcare Research and Quality (AHRQ) derived from 3,072,311 CY 2010 health records for patients 65 or older. AHRQ statistics showed that approximately 32 percent of these patients were considered to have high-risk medical profiles and 68 percent of patients had no-risk (33 percent) or low-risk (35 percent) medical profiles. These statistics are displayed in Figure 2. See Appendix A for a detailed explanation of AHRQ's patient-risk statistics. For purposes of this report, we accounted for patients whose clinical needs would prevent them from having covered surgical procedures in ASCs by excluding a percentage of patients with high-risk medical profiles (32 percent) from our estimates.

**Figure 2: AHRQ Patient Medical Profile Risk Analysis**




## Prior OIG Work Identified a Payment Differential

In 2003, the Office of Inspector General (OIG) issued a report[12] stating that a payment differential existed between ASC and outpatient department Medicare payment rates, as identified in the OPPS and ASCPPS fee schedules. For 66 percent of the procedure codes examined for CY 2001, outpatient department payment rates were higher than ASC payment rates, with a median difference of $282.33. For the remaining 34 percent of procedure codes reviewed, ASC payment rates were higher than outpatient department payment rates, with a median difference of $135.78. We estimated Medicare paid $1.1 billion more for services provided in outpatient departments during CY 2001 than it would have paid if outpatient department payment rates equaled ASC payment rates.

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[11] *Medicare Claims Processing Manual*, Pub. No. 100-04, ch. 14, § 20.1.

[12] *Payment for Procedures in Outpatient Departments and Ambulatory Surgical Centers* (OEI-05-00-00340, issued Jan. 2003).

## HOW WE CONDUCTED THIS REVIEW

We limited our review to Medicare Part B payments to ASCs and outpatient departments for ASC-approved procedures performed during CYs 2007 through 2011. From a total of approximately $12.6 billion that Medicare paid to ASCs for procedures performed during that period, we reviewed claims that included 413 ASC-approved HCPCS codes (representing 96 percent of procedures performed in ASCs and 95 percent of Medicare payments at ASCs). We selected the 413 HCPCS codes that during any 1 year of our audit period: (1) were performed at ASCs at least 1,000 times or (2) for which Medicare reimbursed at least $1 million. We compared the average Medicare payments for the selected HCPCS codes at ASCs and outpatient departments to identify the payment differential during the review period.

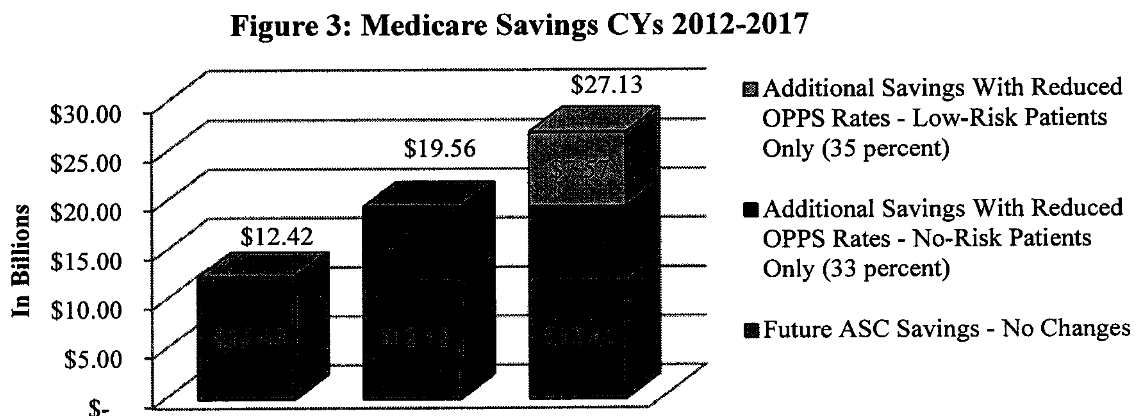
We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A gives details on AHRQ patient-risk data; Appendix B lists the Federal requirements related to ASCs, outpatient departments, and the respective payment systems; and Appendix C provides the details of our audit scope and methodology. Appendix D shows our mathematical calculation methodology, and Appendix E has the results of our calculations.

## FINDINGS

Medicare saved almost $7 billion during CYs 2007 through 2011 and could potentially save $12 billion during CYs 2012 through 2017 because the ASC rates are frequently lower than outpatient department rates for outpatient surgical procedures performed at ASCs. Medicare could generate additional savings of as much as $15 billion if CMS reduces outpatient department payment rates for ASC-approved procedures to ASC payment levels for procedures performed on beneficiaries with low-risk and no-risk clinical needs. Figure 3 summarizes the CYs 2012 through 2017 Medicare savings.

**Figure 3: Medicare Savings CYs 2012-2017**



These Medicare figures do not include savings to the beneficiary for cost sharing. Beneficiaries saved approximately $2 billion during CYs 2007 through 2011. During CYs 2012 through 2017, beneficiaries could potentially save $3 billion because the ASC rates are frequently lower than outpatient department rates for outpatient surgical procedures performed at ASCs. Beneficiaries could potentially save an additional $2 billion to $4 billion during CYs 2012 through 2017 if CMS reduces outpatient department payment rates for ASC-approved procedures to ASC payment levels.

## MEDICARE EXPERIENCED SAVINGS BECAUSE OF THE PAYMENT DIFFERENTIAL

The difference between ASC and outpatient department payment rates saved Medicare almost $7 billion and beneficiaries an additional $2 billion during CYs 2007 through 2011. For 96 percent of the HCPCS codes examined, ASC average payments were lower than outpatient department average payments with the largest median[13] difference of $364.90 occurring in 2009. Table 1 summarizes the median differences of average payments by year for selected HCPCS codes.

**Table 1: Median Differences Between Average ASCPPS and OPPS Payments for Selected HCPCS**

| 2007 | 2008 | 2009 | 2010 | 2011 |
|---|---|---|---|---|
| $294.13 | $341.95 | $364.90 | $348.22 | $363.15 |

Assuming that utilization does not change for ASCs and outpatient departments during CYs 2012 through 2017 from that of CY 2011, Medicare will save approximately $12 billion because of the payment differential. CMS does not need to make any changes, nor do ASCs have to perform any additional procedures, for these savings to occur. Estimated beneficiary savings of approximately $3 billion are in addition to these estimated Medicare savings.

## MEDICARE COULD GAIN ADDITIONAL SAVINGS THROUGH LEGISLATIVE CHANGE FOR LOWER OUTPATIENT PROSPECTIVE PAYMENT SYSTEM PAYMENT RATES

Medicare and its beneficiaries could save more if CMS lowered OPPS payment rates for ASC-approved procedures to the level of ASC payment rates. However without legislative change, budget neutrality required by section 1833(t)(9)(B) of the Act would negate these savings. The budget neutrality adjustment applied to the OPPS rate setting methodology causes any decreases in relative weights to be offset by increases in other relative weights. In effect, lowered rates for some procedures would result in higher rates for others. For Medicare to realize these additional savings long-term, legislation must allow the OPPS rates for ASC-approved procedures to be determined in a non-budget-neutral manner (i.e., outside of section 1833(t)(9)(B) of the Act).

[13] The average differences included several outliers and anomalies. Therefore, we based our analysis on the median rather than the mean.

When calculating potential savings, we assumed that CMS would lower OPPS rates for ASC-approved procedures to at least equal that of ASCPPS rates, when, in fact, CMS could lower rates to any level it deemed reasonable. We calculated the potential savings for CYs 2012 through 2017 by using (1) CY 2011 utilization data, (2) the estimated increase in OPPS payment rates based on changes in the HMB price index and related MFP adjustment, and (3) the estimated increase in the ASCPPS payment rates on the basis of changes in the CPI-U price index and related MFP adjustment.

With legislative change and reduced OPPS rates for ASC-approved procedures, Medicare could generate potential savings of as much as $15 billion during these years for beneficiaries without high-risk medical profiles. We recognize that not all beneficiaries can receive services in an ASC because of the beneficiaries' clinical needs. To account for these beneficiaries, we used AHRQ statistics to exclude procedures for a percentage of beneficiaries with high-risk medical profiles (32 percent of patients) and reduced our total estimated savings to a range of approximately $7 billion to $15 billion. These savings are stated as a range to present potential savings of $7 billion for those procedures performed on beneficiaries with only no-risk medical profiles (33 percent of patients), to potential savings of $15 billion for those procedures performed on beneficiaries with only low- and no-risk medical profiles (68 percent of patients). In addition, these beneficiaries could potentially save an additional $2 billion to $4 billion during these years.

We recognize that when procedures must be performed in an outpatient department because of the beneficiary's clinical needs, higher costs would be possible. As such, these services could be reimbursed at the standard OPPS rate.[14]

## CONCLUSION

As a result of the payment differential, Medicare saved almost $7 billion and beneficiaries saved an additional $2 billion during CYs 2007 through 2011. Also, Medicare and beneficiaries could save an additional $12 billion and $3 billion, respectively, during CYs 2012 through 2017. We estimated that Medicare could save as much as $15 billion more and beneficiaries could potentially save as much as $4 billion more if CMS changes the way it pays outpatient departments for certain ASC-approved procedures.

## RECOMMENDATIONS

We recommend that CMS:

- seek legislation that would exempt the reduced expenditures as a result of lower OPPS payment rates from budget neutrality adjustments for ASC-approved procedures.

[14] However, if Congress makes the recommended legislative change and CMS reduces OPPS rates for ASC-approved procedures, we do not intend for CMS to use AHRQ statistics to implement the reduced OPPS rates or any necessary exceptions to those rates.

If Congress passes the budget-neutrality exemption for the reduced expenditures, we recommend that CMS take the following actions, which we estimated could save as much as $15 billion for CYs 2012 through 2017:

- reduce OPPS payment rates for ASC-approved procedures on beneficiaries with no-risk or low-risk clinical needs in outpatient departments and then

- develop and implement a payment strategy in which outpatient departments would continue to receive the standard OPPS payment rate for ASC-approved procedures that must be provided in an outpatient department because of a beneficiary's individual clinical needs.

## CMS COMMENTS

In written comments on our draft report, CMS did not concur with our recommendations. CMS stated that adopting the recommendations would require legislation and that such a proposal is not currently included in the President's Budget. CMS also noted that the recommended changes "...may raise circularity concerns with respect to the rate calculation process" because most ASC payment rates are based on the OPPS payment rates that we are recommending that CMS reduce and that OIG did not provide specific clinical criteria to distinguish patients' risk levels. CMS's comments are included in their entirety as Appendix F.

## OFFICE OF INSPECTOR GENERAL RESPONSE

We continue to recommend that CMS draft, and submit for review, a legislative proposal that would exempt the reduced expenditures as a result of lower OPPS payment rates from budget neutrality adjustments for consideration for inclusion in future budget and legislative agendas. As part of the process for developing the President's Budget, CMS identifies program vulnerabilities and offers solutions for addressing them. CMS has the authority to develop legislative proposals for Medicare and has historically addressed some OIG recommendations to seek legislative change by developing legislative proposals for possible inclusion in the President's budget and legislative program. Safeguarding programs from fraud, waste, and abuse is an ongoing program management responsibility and some issues may require legislation to address. We look forward to CMS's final management decision in light of this clarification of the intent of our recommendations.

Also, we agree that we did not provide specific clinical criteria to distinguish patients' risk levels and that, depending on the method used to implement our recommendations, circularity concerns may arise. However, that does not prevent implementation of our recommendations. CMS is in the best position to determine how to assess a patient's risk and to develop a payment strategy that would reduce OPPS payments for no- and low-risk patients without disrupting the current payment methodologies. Considering the potential savings identified in our report, we maintain that CMS should take the necessary steps to implement our recommendations.

## APPENDIX A: CONSIDERING PATIENT RISK USING AGENCY FOR HEALTHCARE RESEARCH AND QUALITY DATA

To account for patient risk, OIG obtained statistics from the Healthcare Cost and Utilization Project (HCUP).

The HCUP is a family of health care databases and related software tools and products developed through a Federal-State-industry partnership and sponsored by AHRQ. HCUP includes the largest collection of hospital care data in the United States, with encounter-level information beginning in 1988. HCUP databases bring together the data collection efforts of State data organizations, hospital associations, private data organizations, and the Federal Government to create a national information resource of patient-level health care data.

AHRQ officials provided us with research data from a study AHRQ did of the HCUP exploring short-stay (less than 2 days) surgeries performed for adults 65 and older with common risk factors (defined below) using CY 2010 data from 27 State data organizations that participate in HCUP State Inpatient Databases and State Ambulatory Surgery Databases. The organizations came from these States: California, Colorado, Connecticut, Florida, Georgia, Hawaii, Iowa, Illinois, Indiana, Kansas, Kentucky, Maryland, Michigan, Minnesota, Missouri, North Carolina, Nebraska, New Jersey, New York, Ohio, Oklahoma, Oregon, South Carolina, South Dakota, Tennessee, Vermont, and Wisconsin.

AHRQ officials used a population of 3,072,311 HCUP records during CY 2010 for patients meeting the following criteria:

- 65 or older,
- treated and discharged at community nonrehabilitation hospitals,
- with inpatient stays of 2 days or less, and
- whose patient records included at least one diagnosis or procedure code fitting the HCUP narrow definition of "surgery."

**Patient-Risk Level Defined**

AHRQ officials identified patients as high risk, low risk, or no risk on the basis of the following risk factor conditions: age 80 and older, cancer, diabetes, mental health and substance abuse disorders, nervous system disorder, heart disease, asthma/chronic obstructive pulmonary disease, renal failure, arthritis, or obesity. A high-risk patient was defined as having two or more of these risk factor conditions. A low-risk patient was defined as having one of these risk factor conditions. A no-risk patient was defined as having none of these risk factor conditions. AHRQ officials defined these risk factors by grouping chronic diagnosis codes and then identifying records of patients with discharges including these diagnosis codes.

**Agency for Healthcare Research and Quality Data Results**

Of the 3,072,311 patient-discharge records in the population, 32 percent included two or more risk factors and were considered high risk. Thirty-five percent included one risk factor and were considered as having low risk. The remaining 33 percent were considered as having no risk because the record did not contain any of the selected risk factors. Table 2 summarizes these patient risk level results.

**Table 2: Patient-Risk Levels**

| Risk Factors | Percent of Total | Low- and No-Risk | No-Risk |
|---|---|---|---|
| No-Risk (0 factors) | 33% | 33% | 33% |
| Low-Risk (1 factor) | 35% | 35% | |
| High-Risk (2 or more factors) | 32% | | |
| **Total** | **100%** | **68%** | **33%** |

These results show that approximately 32 percent of patients have a high-risk medical profile and that the remaining 68 percent of patients have no-risk (33 percent) or low-risk (35 percent) medical profiles.

## APPENDIX B: FEDERAL REQUIREMENTS

### FEDERAL REQUIREMENTS FOR AMBULATORY SURGICAL CENTER-APPROVED PROCEDURES

Federal regulations at 42 CFR § 416.166 state that surgical procedures in an ASC that are covered by Medicare (ASC-approved) must include only outpatient surgeries that CMS has determined do not pose a significant safety risk to the patient when furnished in an ASC, are not expected to require active medical monitoring at midnight following the procedure (i.e., an overnight stay), and are separately paid under OPPS. Excluded surgical procedures have the following characteristics:

(1) Generally result in extensive blood loss;

(2) Require major or prolonged invasion of body cavities;

(3) Directly involve major blood vessels;

(4) Are generally emergent or life threatening in nature;

(5) Commonly require systemic thrombolytic therapy;

(6) Are designated as requiring inpatient care under § 419.22(n);

(7) Can only be reported using a CPT [common procedural terminology] unlisted surgical procedure code; or

(8) Are otherwise excluded under § 411.15.

### FEDERAL REQUIREMENTS FOR THE OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

Sections 1833(t)(1)(A) and (t)(1)(B)(i) of the Act require the establishment of a prospective payment system for covered outpatient department services. Covered outpatient department services are designated by the Secretary. Section 419.2(a) of 42 CFR states the services are identified by HCPCS codes.

The basic methodology for determining OPPS payment rates is set forth in 42 CFR part 419 subpart C. Section 419.31(a) states that CMS classifies outpatient services and procedures into APC groups on the basis of clinical and resource use similarity. Section 419.32(c) defines the OPPS payment rate as the product of the OPPS conversion factor and APC relative weight, and section 419.32(b) states that the OPPS conversion factor is updated yearly partly on the basis of the HMB percentage increase. Section 419.32(b)(1)(iv)(B)(3) states that the percentage increase determined under (b)(1)(IV)(a) is reduced by the following for the specified year and for CY 2012: a multifactor adjustment and a 0.1 percentage point. The APC relative weights are determined by a process explained in section 419.31(b).

Section 1833(t)(3)(F)(i) of the Act requires that the OPPS increase factor be reduced by the productivity adjustment for 2012 and subsequent years. Sections (t)(3)(F)(ii) and (t)(3)(G)(ii) discuss additional adjustments for 2010 through 2019.

Section 419.41(b) of 42 CFR states that, each year, CMS calculates the Medicare payment percentage for each APC group on the basis of each group's unadjusted copayment amount and its payment rate adjusted by the conversion factor. For each APC group, the beneficiary's coinsurance percentage is the greater of 20 percent or the ratio of the APC group unadjusted copayment amount to the APC group payment rate (42 CFR § 419.40(b)(1)). However, the coinsurance percentage cannot exceed 40 percent (42 CFR § 419.41(c)(4)(iii)). In addition, the copayment amount cannot exceed the amount of the inpatient hospital deductible (42 CFR § 419.41(c)(4)(i)).

## FEDERAL REQUIREMENTS FOR THE AMBULATORY SURGICAL CENTER PROSPECTIVE PAYMENT SYSTEM

Section 626(b)(2) of the MMA required CMS to revise the ASC payment system no later than January 1, 2008. Subparagraph (D) of section 1833(i)(2) of the Act, as added by the MMA and later amended by section 5103 of the Deficit Reduction Act of 2005, reads as follows:

> (D)(i) Taking into account the recommendations in the report under section 626(d) of Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the Secretary shall implement a revised payment system for payment of surgical services furnished in ambulatory surgical centers.
> (ii) In the year the system described in clause (i) is implemented, such system shall be designed to result in the same aggregate amount of expenditures for such services as would be made if this subparagraph did not apply, as estimated by the Secretary and taking into account reduced expenditures that would apply if subparagraph (E) were to continue to apply, as estimated by the Secretary.
> (iii) The Secretary shall implement the system described in clause (i) for periods in a manner so that it is first effective beginning on or after January 1, 2006, and not later than January 1, 2008.

The ASC rate setting methodology under the revised ASC payment system is set forth in 42 CFR § 416 subpart F. Section 416.167(a) includes the requirement that covered surgical procedures and covered ancillary services are identified by codes established under the HCPCS as the unit of payment. Section 416.167(b)(1) states that ASC-covered surgical procedures are classified using the APC groups described in section 419.31. Section 416.171 describes the determination of payment rates. Specifically, section 416.171(a) states the standard methodology is to calculate the product of the ASC conversion factor and the APC relative payment weight. Section 416.171(a)(2)(ii) states that, for CY 2010 and subsequent CYs, the ASC conversion factor is updated using the CPI-U. The APC relative weights are determined by a process explained in section 416.167(b).

Section 1833(i)(2)(D)(v) of the Act requires that, effective for CY 2011 and subsequent years, any annual update under the ASC payment system be reduced by a productivity adjustment.

Charges for services covered under the ASCPPS beyond the 80 percent Medicare covers are the beneficiary's responsibility. For ASC services furnished on or after January 1, 2008, "Medicare Part B pays the lesser of 80 percent of the actual charge or 80 percent of the prospective payment amount, geographically adjusted, if applicable ..." (42 CFR § 410.152(i)(2)). Therefore, the beneficiary's financial responsibility "is 20 percent of the actual charge or 20 percent of the prospective payment amount, geographically adjusted, if applicable."

## FEDERAL REQUIREMENTS FOR BUDGET NEUTRALITY

Section 1833(t)(9)(B) of the Act regarding the OPPS states that "[i]f the Secretary makes adjustments under subparagraph (A), then the adjustments for a year may not cause the estimated amount of expenditures under this part for the year to increase or decrease from the estimated amount of expenditures under this part that would have been made if the adjustments had not been made."

Section 1833(i)(2)(D) of the Act regarding the ASCPPS states that "a revised payment system for payment of surgical services furnished in ambulatory surgical centers ... shall be designed to result in the same aggregate amount of expenditures for such services as would be made if this subparagraph did not apply, as estimated by the Secretary and taking into account reduced expenditures that would apply if subparagraph (E) were to continue to apply, as estimated by the Secretary."

In the Final Rule, CMS-1517-F (72 Fed. Reg. 42470, 42533 (Aug. 2, 2007)), CMS stated that it will "update the ASC relative payment weights in the revised ASC payment system each year using the national OPPS relative payment weights for that same calendar year and uniformly scale the ASC relative payment weights for each update year to make them budget neutral."

## APPENDIX C: AUDIT SCOPE AND METHODOLOGY

### SCOPE

We limited our review to Medicare Part B payments to ASCs and outpatient departments for ASC-approved procedures paid for during CYs 2007 through 2011. We identified average Medicare payments and the numbers of procedures performed in ASCs and outpatient departments. We limited our review to only those HCPCS codes during any given year (1) that were performed at ASCs at least 1,000 times or (2) for which Medicare reimbursed ASCs at least $1 million. The selected sample was 413 HCPCS codes during the period under review and represents 96 percent of procedures performed and 95 percent of Medicare payments at ASCs.

Using this information, we compared the average Medicare payments for the selected HCPCS codes at ASCs and outpatient departments to identify the payment differential during the review period. We determined the amount that could have been saved had all HCPCS in our sample been performed at ASCs during this period. Furthermore, we calculated the potential Medicare savings from CYs 2012 through 2017 using CY 2011 utilization and payment rates. We did not adjust our calculations to include changes in utilization; however, we did adjust for changes in payment rates using the annual HMB and CPI-U price index updates and the MFP adjustments.

We used CY 2011 payment rates because 2011 was the first year that CMS calculated ASC payment rates using only the revised methodology established under 42 CFR § 416 subpart F. Federal regulations required CMS to implement the ASCPPS using a transitional period during CYs 2008 through 2010 (42 CFR § 416.171(c)). In addition, CY 2011 was the most current year of data available at the time.

We did not review the overall internal control structure of CMS as it relates to the Medicare payment system for ASCPPS and OPPS. Rather, we limited our internal control review to those controls that related to the objective of our audit.

We conducted fieldwork at the CMS Central Office in Baltimore, Maryland, from February through November, 2012.

### METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- held discussions with CMS officials to identify and gain an understanding of policies and procedures related to the ambulatory surgical services and hospital outpatient department programs;
- obtained Medicare utilization and payment data from the CMS's National Claims History File by HCPCS code for ambulatory surgical services provided in ASCs and outpatient departments for the period January 1, 2007, through December 31, 2011;

- obtained CYs 2013 through 2017 estimated HMB and CPI-U price index updates and respective MFP adjustments from CMS's Office of the Actuary (OACT);
- identified total Medicare expenditures related to all procedures performed in ASC and outpatient department settings;
- created a sampling frame of 12,182 HCPCS codes that were associated with 3.4 billion procedures performed totaling $234 billion for the 5-year period under review which included:
  - 35 million procedures reimbursed at ASCs for Medicare payments totaling $13 billion; and
  - 3.4 billion procedures reimbursed at outpatient departments for Medicare payments totaling $221 billion;
- selected from the sampling frame a judgmental sample of 413 HCPCS codes:[15]
  - that were performed at ASCs at least 1,000 times during any 1 year[16] or
  - for which Medicare reimbursed ASCs at least $1 million during any 1 year;
- calculated ASCPPS payments as a percentage of OPPS payments for each year and for the combined 5-year audit period;
- calculated the average Medicare payment per HCPCS code in both the ASC and outpatient department settings;
- calculated the difference between average Medicare payments for procedures performed in ASCs and average Medicare payments for the same procedures performed in outpatient departments;
- calculated Medicare savings for each year in our audit period by multiplying utilization by the difference between average ASC and outpatient department Medicare payments;
- calculated future potential savings using CY 2011 utilization data and the difference between the average ASC and outpatient department payments updated each year for estimated changes in the CPI-U and HMB price indexes and the MFP adjustments;

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[15] These 413 HCPCS codes related to 96 percent of procedures performed and 95 percent of Medicare reimbursements during the audit period. Specifically, Medicare reimbursed providers $12,089,489,909 for 33,767,338 procedures performed at ASCs and $35,732,207,819 for 56,806,824 of the same procedures performed at outpatient departments during our audit period.

[16] The selection criteria specify that the condition need only be met during any 1 year, so many HCPCS codes may not meet the criteria during all years.

- obtained AHRQ statistical data on patient risk and applied the data to our findings (Appendix B);
- identified that 20 percent is a conservative and approximate amount of beneficiary cost sharing and applied the percentage to our findings;
- determined the effects of budget neutrality on changes in utilization and payment rates; and
- discussed the results of our review with CMS officials.

See Appendix D for our mathematical calculation methodology and Appendix E for our sample results and potential savings.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

## APPENDIX D: MATHEMATICAL CALCULATION METHODOLOGY

### MEDICARE SAVINGS FOR 2007 THROUGH 2011

To determine the savings Medicare experienced during CYs 2007 through 2011 because of the payment differential, we calculated the difference between the average Medicare payments in ASCs and outpatient departments for each HCPCS code in each year, multiplied the difference in average payment by the ASC utilization, and totaled each year's results.

### POTENTIAL MEDICARE SAVINGS FOR 2012 THROUGH 2017

To estimate the savings Medicare could experience during CYs 2012 through 2017 because of the payment differential, we used CY 2011 ASC utilization and estimated increases in payment rates using HMB and CPI-U estimates and MFP adjustments. We calculated the difference between the projected average Medicare payments in ASCs and outpatient departments for each HCPCS code during the timeframe.

### POTENTIAL MEDICARE SAVINGS FOR 2012 THROUGH 2017 BY LOWERING OUTPATIENT PROSPECTIVE PAYMENT SYSTEM PAYMENT RATES TO EQUAL AMBULATORY SURGICAL CENTER PROSPECTIVE PAYMENT SYSTEM RATES

To estimate the potential Medicare savings for CYs 2012 through 2017 if CMS lowered OPPS rates to equal ASCPPS rates, we used (1) CY 2011 outpatient department utilization, (2) the estimated increase in OPPS payment rates based on changes in the HMB price index and related MFP adjustment, and (3) the estimated increase in the ASCPPS payment rates based on changes in the CPI-U price index and related MFP adjustment. We did not estimate for increases in utilization. We calculated the difference between the estimated average Medicare payments in ASCs and outpatient departments for each HCPCS code, multiplied that difference by the 2011 utilization amounts, summed the total for all HCPCS, and summed the yearly totals for CYs 2012 through 2017.

We adjusted the estimated total savings to reflect a range of more conservative savings for procedures that cannot be performed in an ASC because of patient risk by multiplying the estimated savings by 33 percent and 68 percent.

## APPENDIX E: POTENTIAL SAVINGS FOR THE SELECTED SAMPLE

**Table 3: Results**

| Year | HCPCS Codes | ASCs | | Outpatient Departments | |
|---|---|---|---|---|---|
| | | Utilization | Reimbursements | Utilization | Reimbursements |
| **2007** | 335 | 6,183,115 | $2,234,435,661 | 11,294,362 | $5,261,148,371 |
| **2008** | 389 | 6,715,120 | 2,344,484,318 | 11,633,361 | 6,528,775,831 |
| **2009** | 386 | 7,037,850 | 2,434,219,342 | 12,380,024 | 7,434,935,153 |
| **2010** | 390 | 7,267,716 | 2,510,848,058 | 10,463,074 | 7,943,756,809 |
| **2011** | 392 | 6,563,537 | 2,565,502,530 | 11,036,003 | 8,563,591,655 |
| **Total** | **413**[17] | **33,767,338** | **$12,089,489,909** | **56,806,824** | **$35,732,207,819** |

**Table 4: Estimated Medicare Savings for CYs 2007 Through 2011**

| Year | Estimated Savings |
|---|---|
| **2007** | $ 795,652,581 |
| **2008** | 1,084,518,402 |
| **2009** | 1,448,920,045 |
| **2010** | 1,648,016,920 |
| **2011** | 1,835,751,695 |
| **Total** | **$6,812,859,643** |

**Table 5: Potential Medicare Savings for CYs 2012 Through 2017**
**If Utilization and Payment Rates Remain the Same**

| Year | Potential Savings |
|---|---|
| **2012** | $ 1,882,726,731 |
| **2013** | 1,952,384,520 |
| **2014** | 2,016,314,061 |
| **2015** | 2,097,978,560 |
| **2016** | 2,191,812,068 |
| **2017** | 2,280,568,191 |
| **Total** | **$12,421,784,131** |

[17] The total amount of HCPCS codes selected is not equal to the sum of all HCPCS performed from CYs 2007 through 2011. The selection criteria specify that the condition need only be met during any 1 year to be included in the sample.

**Table 6: Additional Possible Medicare Savings for CYs 2012 Through 2017 by Lowering Outpatient Prospective Payment System Payment Rates To Equal Ambulatory Surgical Center Prospective Payment System Rates**

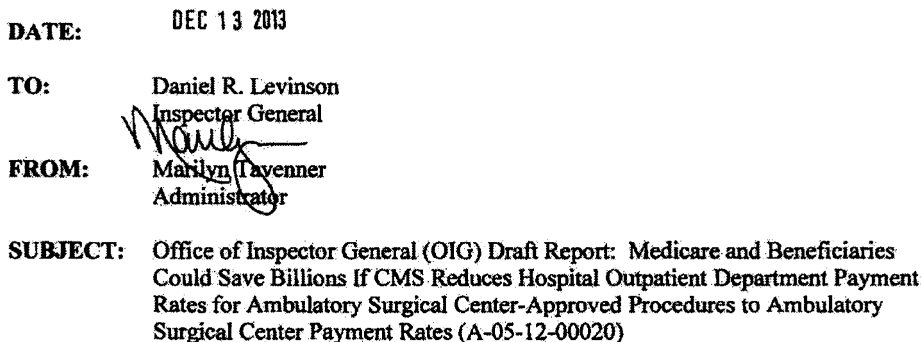
| Year | Savings Including 68% of the At-Risk Population | Savings Including 33% of the At-Risk Population |
|---|---|---|
| **2012** | $2,211,745,417 | $1,073,347,042 |
| **2013** | 2,302,229,829 | 1,117,258,593 |
| **2014** | 2,382,881,818 | 1,156,398,529 |
| **2015** | 2,486,667,984 | 1,206,765,345 |
| **2016** | 2,606,478,140 | 1,264,908,509 |
| **2017** | 2,718,636,081 | 1,319,338,098 |
| **Total** | **$14,708,639,269** | **$7,138,016,116** |

## APPENDIX F: CMS COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

*Administrator*
Washington, DC 20201



**DATE:** DEC 13 2013

**TO:** Daniel R. Levinson
Inspector General

**FROM:** Marilyn Tavenner
Administrator

**SUBJECT:** Office of Inspector General (OIG) Draft Report: Medicare and Beneficiaries Could Save Billions If CMS Reduces Hospital Outpatient Department Payment Rates for Ambulatory Surgical Center-Approved Procedures to Ambulatory Surgical Center Payment Rates (A-05-12-00020)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and respond to the above subject OIG draft. OIG stated that the objectives of its review were to determine how much Medicare--(1) Has saved as a result of procedures being performed in Ambulatory Surgical Centers (ASCs) instead of outpatient departments; and (2) Could save if payment rates for the outpatient departments were reduced to the same level as ASC payment rates. According to OIG, Medicare saved almost $7 billion during calendar years (CYs) 2007 through 2011 and could potentially save $12 billion from CYs 2012 through 2017 because ASC rates are frequently lower than outpatient department rates for surgical procedures. In addition, Medicare could generate savings of as much as $15 billion for CYs 2012 through 2017 if CMS reduces outpatient department payment rates for ASC-approved procedures to ASC payment levels for procedures performed on beneficiaries with low risk and no-risk clinical needs.

The OIG recommendations and the CMS response to those recommendations are discussed below.

**<u>OIG Recommendations</u>**

The OIG recommends that CMS seek legislation that would exempt the reduced expenditures as a result of lower outpatient perspective payment system (OPPS) payment rates from budget neutrality adjustments for ASC-approved procedures.

If Congress passes the budget-neutrality exemption for the reduced expenditures, OIG recommends that CMS take the following actions, which OIG estimated could save as much as $15 billion from CYs 2012 through 2017:

- Reduce OPPS payment rates for ASC-approved procedures on beneficiaries with no-risk or low-risk clinical needs in outpatient departments.

- Develop and implement a payment strategy in which outpatient departments would continue to receive the standard OPPS payment rate for ASC-approved procedures that must be provided in an outpatient department because of a beneficiary's individual clinical needs.

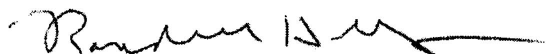
**CMS Response**

We do not concur with the recommendations. As OIG's recommendations indicate, adopting these recommendations would require legislation and such a proposal is not currently included in the President's Budget. We further note that most ASC payment rates are based on the OPPS relative payment weights and an ASC-specific conversion factor. Because most ASC rates are based on OPPS rates, OIG's recommendations may raise circularity concerns with the respect to the rate calculation process. Lastly, we note that OIG suggests no specific clinical criteria to distinguish patients that can be adequately treated in an ASC relative to the hospital outpatient setting that would be needed to act on these recommendations.

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

Exhibit 16.
Affirmations

I hereby declare and affirm under the penalties of perjury that the facts stated in this Completeness and Additional Information response are true and correct to the best of my knowledge, information, and belief.

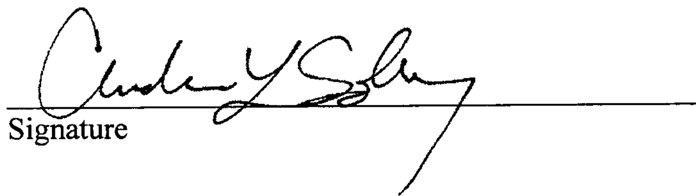


Signature

8-11-2016

Date

I hereby declare and affirm under the penalties of perjury that the facts stated in this Completeness and Additional Information response are true and correct to the best of my knowledge, information, and belief.



Signature

8/10/16

Date