



Advising the Congress on Medicare issues

Addressing Medicare payment differences across settings: Ambulatory care services

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Overview

- Multiple payment systems for ambulatory services
 - But similar patients receive similar services
- Payment rates vary across systems for same service
 - E.g., rate for laser eye procedure is 90% higher in outpatient department (OPD) than physician's office
- Raises program spending and beneficiary cost sharing

Payment principles

- Patients should have access to settings that provide appropriate level of care
- Prudent purchaser should not pay more for a service in one setting than another
- Medicare should base payment rates on resources needed to treat patients in lowest-cost, clinically appropriate setting

Reasons why payment rates could differ by ambulatory setting

- Hospitals incur costs related to standby capacity and emergency care
- Differences in patient severity that may affect costs
- Differences in the unit of payment
 - E.g., OPD payment unit includes more ancillaries than physician fee schedule

Payment rates for ambulatory services often vary by setting

- OPD rates often higher than physician office rates
 - Some services are paid same (e.g., MRI, outpatient therapy, clinical lab tests)
- Shift of services from physicians' offices to OPDs
 - E.g., share of echocardiograms provided in OPDs grew from 22 percent in 2008 to 25 percent in 2010
- Recommendation to equalize rates for non-emergency E&M visits across settings (March 2012)

Addressing payment variations for other ambulatory services

- We have evaluated other ambulatory services that have payment disparities between settings
- For some services, payments could be equal across settings
- For other services, payments could be higher in OPDs but the magnitude of the difference could be narrowed

Criteria for services that could have equal rates across settings

- Frequently performed in physicians' offices (more than 50% of time)
- Similar unit of payment (ancillaries are less than 5% of total cost of service in outpatient system)
- Infrequently provided with an ED visit (less than 10%)
- Minimal difference in patient severity across settings

Services that meet potential criteria for equal rates across settings (Group 1)

- 25 Ambulatory Payment Classifications (APCs)
- Most are diagnostic tests, such as
 - Level II echocardiogram without contrast
 - Level II extended EEG, sleep, and cardiovascular studies
 - Bone density testing
 - Level II neuropsychological testing
- Some are procedures, such as laser eye surgery

Services for which payment differences could be narrowed (Group 2)

- 61 APCs
- Meet 3 of the 4 criteria for equal payments across settings
- But OPPS has more packaging of ancillaries than does the PFS
- OPPS rates could be set to
 - Amount needed for equal payments in OPDs and freestanding offices, plus
 - Cost to OPDs for additional packaging of ancillaries

Summary of two groups

Group 1 (equal payments)

> 50% in offices
< 5% packaging
< 10% in EDs
Similar patient severity
across settings

Group 2 (reduce differences)

> 50% in offices
> 5% packaging
< 10% in EDs
Similar patient severity
across settings

Setting OPPS rates for Group 1 (Example: laser eye procedures)

| | Visit in office | Visit in OPD | |
|---|-------------------|----------------------------|------------------------------|
| | | Current rates | Limit on OPPS rate |
| Fee schedule rate | \$389 | \$360 | \$360 |
| OPPS rate | N/A | 379 | 30 |
| Total payment (Pct difference) | 389 --- | 738 (90%) | 389 (equal) |

Setting OPPS rates for Group 2 (Example: level I echocardiogram)

| | Visit in office | Visit in OPD | |
|-------------------------|-----------------|---------------|------------------------|
| | | Current rates | Limit on OPPS rate |
| Fee schedule rate | \$143 | \$44 | \$44 |
| OPD payment | | | |
| OPPS rate | N/A | 275 | 99 |
| Packaging | N/A | N/A | 41 |
| Total payment | 143 | 319 | 184 |
| (Pct difference) | --- | (123%) | (29% from pckg) |

Aggregate policy effects (one year)

- Program spending would decline by \$900 million
- Beneficiary cost sharing would decline by \$250 million

Note: Estimates are preliminary and subject to change

Effects of reducing OPD rates for both groups of service, by hospital category

| Hospital group | Decline in overall revenue | Decline in OPD revenue |
|-----------------------------|----------------------------|------------------------|
| 10 th percentile | 0.2% | 1.4% |
| 90 th percentile | 2.0 | 6.8 |
| Urban | 0.7 | 3.3 |
| Rural | 1.2 | 4.2 |
| Major teaching | 0.7 | 3.6 |
| Other teaching | 0.6 | 3.1 |
| Non-teaching | 0.8 | 3.5 |
| Voluntary | 0.7 | 3.4 |
| Proprietary | 0.7 | 3.5 |
| Government | 0.8 | 3.6 |
| All hospitals | 0.7 | 3.4 |

Note: Estimates are preliminary and subject to change

Comparing 100 hospitals that would see largest payment reductions to all hospitals

| Variable | 100 hospitals w/ largest reductions | All hospitals |
|-----------------|--|---------------|
| Avg loss | 4.8% | 0.7% |
| Median DSH pct | 12.5 | 25.6 |
| Pct major teach | 7.0 | 8.3 |
| Pct rural | 24.0 | 28.9 |
| Pct voluntary | 39.0 | 59.4 |
| Pct proprietary | 58.0 | 24.3 |
| Pct government | 3.0 | 16.3 |

Note: Estimates are preliminary and subject to change

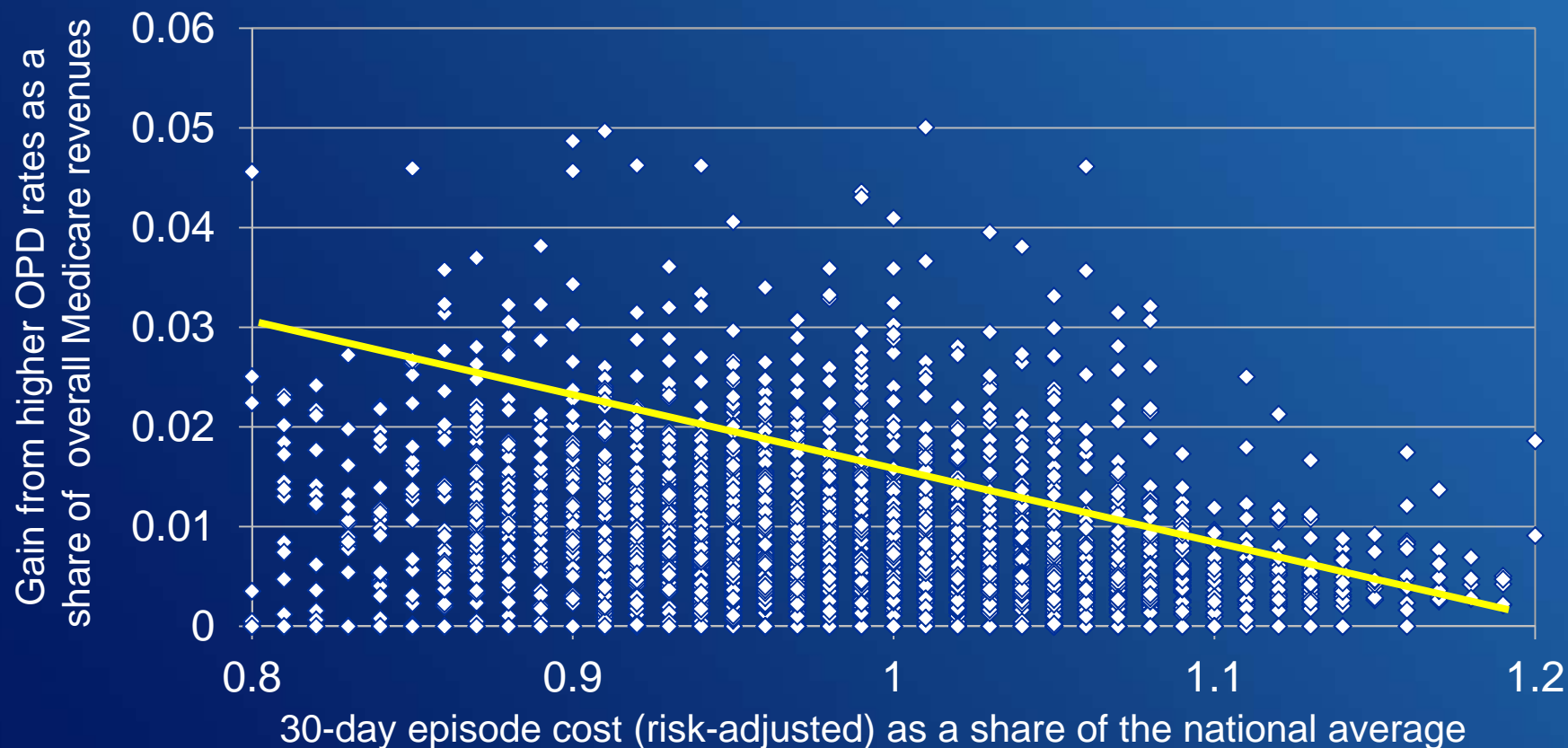
Characteristics of 100 hospitals that would see largest payment reductions

- Much smaller than average hospital
- 60 of top 100 are specialty hospitals
 - 47 of 60 are orthopedic/surgical hospitals, which tend to focus on outpatient care
 - Specialty hospitals less likely to have EDs
- ED visits much smaller share of Medicare revenue compared with other hospitals

Other issues

- Using PFS rates as benchmark for OPD rates
 - Although we have concerns about access to primary care, overall access to PFS services is good (March 2012)
 - Commission recommendations to improve process for identifying misvalued services
 - Because of recommendations and other changes, payment rates for primary care have increased
- Do hospitals that benefit from higher OPD rates have lower Medicare spending per episode?

Weak relationship between hospitals' benefit from higher payments for certain outpatient services and episode costs



For Commission discussion

- Feedback on policy options to eliminate or reduce payment differences
- Differences across settings for services that are often provided with ED visit or have differences in patient severity
- Additional questions/research