



Advising the Congress on Medicare issues

Addressing Medicare payment differences across settings: Ambulatory care services

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Overview

- Importance of addressing payment differences across settings
- Aligning payment rates across settings for E&M visits and additional services
- Impact on spending, cost sharing, hospitals
- Mitigating impact on hospitals that serve many low-income patients

Growth of hospital employment of physicians

- Number of physicians employed by hospitals increased by 55% from 2003-2011 (AHA survey)
- Share of cardiologists employed by hospitals grew from 11% to 35% from 2007-2012 (ACC survey)

Number of services per beneficiary growing faster in OPDs than freestanding offices, 2010-2011

Type of service	Growth in freestanding office	Growth in OPD	Share of services in OPDs, 2011
E&M office visits	-0.2%	7.8%	9.7%
Echocardiogram (without contrast)	-6.3	17.6	29.6
Nuclear cardiology	-12.0	13.6	33.0

Note: E&M (evaluation and management). Data are preliminary and subject to change
 Source: MedPAC analysis of Medicare claims, 2010-2011

If migration to OPDs continues at current rate...

- Medicare spending on E&M visits would be \$1.2 billion higher per year by 2021 due to shift in site of care; beneficiary cost sharing would be \$310 million higher
- Medicare spending on echocardiograms and nuclear cardiology studies would be \$1.1 billion higher per year by 2021; cost sharing would be \$285 million higher

Principles for paying for same service in different settings

- 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 should differ by setting for certain services

- Hospitals incur costs related to standby capacity for emergencies and regulatory requirements
- Patient severity may be greater in OPDs
- Outpatient PPS more likely to combine primary service with ancillaries into a single payment (packaging)

Recommendation to equalize rates for E&M visits across settings (March 2012)

- Standby capacity/emergency care should not affect costs of E&M visits outside of ED
- CPT codes reflect differences in patient complexity
- Level of packaging only slightly higher in outpatient PPS than in PFS
- 3 year phase-in, stop-loss policy for hospitals with high share of low-income patients
- Annual total savings: \$820 million
- Annual cost sharing savings: \$190 million

Additional services that meet principles for aligning payment rates between settings

- 66 APCs for which payments could be equalized between OPDs and offices, or differences could be narrowed (Groups 1 and 2)
- 3 cardiac imaging APCs for which payments could be equalized between OPDs and offices
- 12 APCs for which payments could be equalized between OPDs and ASCs

Groups 1 and 2: Payments could be equalized or differences could be narrowed

Group 1 (equal payments across settings)

> 50% in offices
< 5% packaging
< 10% in EDs
Patient severity no greater in OPD
< 5% 90 day global codes

24 APCs

Group 2 (narrow payment differences)

> 50% in offices
> 5% packaging
< 10% in EDs
Patient severity no greater in OPD
< 5% 90 day global codes

42 APCs

Impact of changing payment rates for APCs in Groups 1 and 2 on spending and cost sharing

- Would reduce program spending and beneficiary cost sharing by \$900 million
- Amount beneficiaries save in cost sharing depends on method for determining copayment in each APC
 - Decrease in cost sharing would be \$140 million to \$380 million
 - As savings in cost sharing increase, amount program saves declines

Impact of changing payment rates for APCs in Groups 1 and 2 on hospital revenue

- Would reduce overall hospital Medicare revenue by 0.6% and OPD revenue by 2.7%
 - Greater impact on rural hospitals
- Combined with E&M policy, would reduce overall revenue by 1.2% and OPD revenue by 5.4%
 - Greater impact on rural, major teaching, and government hospitals

Data are preliminary and subject to change

Mitigating impact of payment changes on hospitals

- Concern: Impact on access to ambulatory services for low-income patients
- Policy to mitigate impact on hospitals that serve low-income patients
 - Based on share of low-income patients in OPD or inpatient setting?
 - Use DSH as a proxy?
 - Stop-loss protection or pool of dollars?
- Illustrative example: Limit losses to 2% of overall revenue for hospitals that have DSH > median (25.6%)

Stop-loss: Little effects on Groups 1 and 2 alone; important when combined w/ E&M

Category	Groups 1 & 2	Groups 1 & 2, stop-loss	Groups 1 & 2 + E&M	Groups 1 & 2 + E&M, stop-loss
All hospitals	0.6%	0.6%	1.2%	1.0%
Rural	0.9	0.9	1.7	1.6
Urban	0.5	0.5	1.1	0.9
Nonprofit	0.6	0.6	1.1	1.0
For profit	0.5	0.5	0.8	0.7
Government	0.6	0.6	1.6	1.2
Major teach	0.5	0.5	1.7	1.3
Other teach	0.5	0.5	0.9	0.9
Nonteaching	0.6	0.6	1.1	1.0

Aligning payment rates between OPDs and physicians' offices for cardiac imaging APCs

- Focus on 3 APCs that include cardiac imaging services (269, 270, 377)
- Rapid migration from offices to OPDs
- Share of cardiologists employed by hospitals has tripled
- Payment rates substantially higher in OPDs
- Would reduce program spending and cost sharing by ~\$500 million per year
 - Beneficiaries would save ~\$100 million

Reduction in overall Medicare revenue from reducing OPD payments for cardiac imaging APCs and E&M visits

Category	Cardiac APCs	Cardiac APCs, stop-loss	Cardiac APCs + E&M	Cardiac APCs + E&M, stop-loss
All hospitals	0.3%	0.3%	0.9%	0.8%
Rural	0.5	0.5	1.3	1.2
Urban	0.3	0.3	0.9	0.8
Nonprofit	0.3	0.3	0.9	0.8
For profit	0.3	0.3	0.5	0.5
Government	0.3	0.3	1.3	1.0
Major teach	0.3	0.3	1.4	1.1
Other teach	0.3	0.3	0.7	0.7
Nonteaching	0.4	0.4	0.8	0.7

Characteristics of 100 most affected hospitals: Cardiac imaging APCs

- Relative to all other hospitals:
 - More rural, nonprofit
 - Fewer major teaching, for-profit
 - Far fewer beds
 - Similar DSH percentage
 - 6 specialty hospitals

Equal payment rates between OPDs and ASCs for 12 APCs commonly done in ASCs

- OPD rates for most ambulatory procedures 78% higher than ASC rates
- Gap in payment rates has widened
- Criteria for services that could have equal rates between settings
 - Frequently performed in ASCs (more than 50% of time)
 - Infrequently provided with an ED visit (less than 10%)
 - Patient severity no greater in OPDs than ASCs

Impact of equalizing payment rates for 12 APCs on spending and cost sharing

- Would reduce program spending and cost sharing by \$590 million per year
- Cost sharing would decline between \$40 million and \$220 million, depending on how OPD copayments are determined

Reduction in overall Medicare revenue from reducing OPD payments for 12 APCs and E&M visits

Category	12 APCs	12 APCs, stop-loss	12 APCs + E&M	12 APCs + E&M, stop-loss
All hospitals	0.4%	0.4%	1.0%	0.8%
Rural	0.7	0.6	1.4	1.3
Urban	0.3	0.3	0.9	0.8
Nonprofit	0.4	0.3	0.9	0.9
For profit	0.4	0.4	0.6	0.6
Government	0.4	0.4	1.4	1.1
Major teach	0.3	0.3	1.4	1.2
Other teach	0.3	0.3	0.7	0.7
Nonteaching	0.5	0.5	0.9	0.8

Characteristics of 100 most affected hospitals: 12 APCs

- Relative to other hospitals
 - More likely to be rural, for-profit
 - Far fewer beds
 - Less likely to be nonprofit, major teaching
 - Much lower average DSH percentage
 - 61 specialty hospitals

Summary: Additional services that meet principles for aligning payment rates between settings

- 66 APCs for which payments could be equalized between OPDs and offices, or differences could be narrowed (Groups 1 and 2)
- 3 cardiac imaging APCs for which payments could be equalized
- 12 APCs for which payments could be equalized between OPDs and ASCs

Summary: Impact on overall hospital Medicare revenue and spending

	Revenue reduction	Revenue reduction, including E&M policy	Overall savings (millions)	Beneficiary savings (millions)
Groups 1 and 2 (66 APCs)	0.6%	1.2%	\$900	\$140 - \$380
3 cardiac imaging APCs	0.3	0.9	500	100
12 APCs commonly done in ASCs	0.4	1.0	590	40-220

For discussion

- Questions about analysis
- Discussion of additional services that meet principles for aligning payment rates between settings
- Discussion of ways to reduce beneficiary cost sharing, mitigate impact on hospitals that serve low-income patients