Aligning fee-for-service payment rates across ambulatory settings

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Background on Commission's payment alignment work

- 2012-2014: Commission evaluated effects of aligning payment rates between hospital outpatient departments and physician offices
- November 2021, April 2022: Presented analyses that built on previous Commission work (published in June 2022 report)
- Today:
  - Review previous findings
  - Provide a platform for developing draft recommendations

Differences in Medicare fee-for-service payment rates among ambulatory settings

- Distinct payment systems for three ambulatory settings: Physician offices, hospital outpatient departments (HOPDs), and ambulatory surgical centers (ASCs)
- Payment rates often differ for the same service among ambulatory settings
  - Outpatient prospective payment system (OPPS) has higher payment rates than the physician fee schedule (PFS) and the ASC payment system for most services

Different rates across settings can increase Medicare spending and beneficiary cost sharing

- Payment differences can result in higher-cost providers acquiring lower-cost providers
  - Hospitals can acquire physician practices and bill at higher OPPS rates with little or no change in the site of care
  - Billing of services for office visits, echocardiography, cardiac imaging, and chemotherapy administration has shifted from PFS to OPPS
- Shift of billing increased program outlays and cost sharing
- Bipartisan Budget Act of 2015 aligned OPPS rates with PFS rates in limited instances

Acquisition of physician practices has shifted billing from offices to HOPDs

Service	Share in HOPDs, 2012	Share in HOPDs, 2021
Office visits	9.6%	12.8%
Chemotherapy administration	35.2	51.9
Cardiac imaging	33.9	47.6
Echocardiography	31.6	43.1

Note: HOPD (hospital outpatient department).

Source: MedPAC analysis of standard analytic claims file, 2012 and 2021.

Data preliminary and subject to change

Issues to address when aligning payment rates across ambulatory settings

- Some services cannot be provided in offices or ASCs; must be provided in HOPDs (ED visits, complex procedures)
- OPPS and ASC system have different payment units than PFS
  - More packaging of ancillary items in OPPS and ASC system relative to PFS
- Align payments only if it is reasonable to provide service in lower-cost settings for most beneficiaries

Concern: Relationship between patient severity and costliness

- Regression analysis: Relationship between Charlson comorbidity index (CCI, measure of health status) and HOPD charges for a service
- Relationship between the beneficiary CCI and level of charges was weak; 10% increase in CCI was associated with an increase in charges of less than 1%
- Conclusion: In general, adjustments for patient severity are not needed for effective system of aligning payment rates

Identifying candidate services for aligned payment rates

- Collected services into ambulatory payment classifications (APCs), the payment classification system in the OPPS
- For each APC, used data from 2016-2019 to determine the volume in each ambulatory setting
  - If offices had the highest volume, aligned OPPS and ASC rates with PFS rates
  - If ASCs had the highest volume, aligned OPPS rates with ASC rates; kept PFS rates the same
  - If HOPDs had the highest volume, no change in payment rates

Aligning OPPS payment rates with PFS payment rates: Level 2 nerve injection

	Service in office	Service in HOPD	Service in HOPD with rates aligned
PFS payments			
Work	$64.87	$64.87	$64.87
PE	185.64	31.71	31.71
PLI	5.77	5.77	5.77
OPPS payment	N/A	598.81	153.93
Total payment	$256.28	$701.16	$256.28

$185.64

Note: OPPS (outpatient prospective payment system), PFS (physician fee schedule), HOPD (hospital outpatient department), PE (practice expense), PLI (professional liability insurance).

Source: MedPAC analysis of PFS and OPPS payment rates, 2019.

We identified 68 APCs for which to align payment rates

- 169 APCs for services in OPPS; reasonable to align payment rates for 68 APCs
  - Aligned OPPS and ASC rates with PFS rates for 57 APCs
    - Constitute 22 percent of total spending under OPPS
    - Constitute 11 percent of total spending under ASC system
    - Most of these APCs are low-complexity services (office visits)
  - Aligned OPPS rates with ASC rates for 11 APCs
    - Constitute 4 percent of spending under OPPS
  - Did not align payment rates for the remaining 101 APCs

Data preliminary and subject to change

Aligning payment rates across three ambulatory settings for 68 APCs

- If changes in payments from aligning payment rates were taken as savings:
  - Under OPPS, 2019 cost sharing would decrease by $1.7 billion and program outlays by $6.6 billion (13 percent decrease)
  - Under ASC system, 2019 cost sharing would decrease by $60 million and program outlays by $230 million (6 percent decrease)
- Current law: CMS would increase OPPS payment rates of APCs for which payment rates are not aligned to offset lower payments from payment rate alignment (budget neutrality)

Data preliminary and subject to change

Effects of payment rate alignment policies coupled with required budget neutrality adjustment

- Percent change, total Medicare revenue for hospital categories

Hospital category	Payment alignment policies with budget neutral adjustment
All hospitals	0.0%
Urban	0.2
Rural (no CAHs)	-2.3
Nonprofit	0.0
For-profit	0.1
Government	-0.9

Source: MedPAC analysis of hospital cost reports and standard analytic claims files, 2019.

Data preliminary and subject to change

Alternative #1: Use the lower payment rates on aligned services as program savings

- Using lower payment rates as program savings would have reduced program outlays by $6.6 billion and cost sharing by $1.7 billion in 2019
- This alternative would require Congressional action; current law requires a budget neutrality adjustment

Using effects of lower payment rates as program savings

Hospital category	Percent change to total Medicare revenue
All hospitals	-4.1%
Urban	-3.8
Rural (no CAHs)	-6.9
Nonprofit	-4.1
For-profit	-3.3
Government	-4.6

Source: MedPAC analysis of hospital cost reports and standard analytic claims files, 2019.

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Alternative #2: Use part of the lower payment rates on hospitals that serve vulnerable populations

- Use some of the lower payment rates from payment alignment policies on hospitals that serve vulnerable populations
  - Use DSH percentage to identify hospitals that serve vulnerable populations
  - Illustrative example: Limit hospital's reduction in total Medicare revenue to 4.1% (median loss) if DSH percentage is above median (28.1%)

Effects of payment alignment policies, with and without temporary stop-loss policy

Hospital category	Percent change, total Medicare revenue	
	Without stop-loss	With stop-loss
All hospitals	-4.1%	-3.6%
Urban	-3.8	-3.4
Rural (no CAHs)	-6.9	-5.5
Nonprofit	-4.1	-3.7
For-profit	-3.3	-3.1
Government	-4.6	-3.8

Source: MedPAC analysis of hospital cost reports and standard analytic claims files, 2019.

Data preliminary and subject to change

Rationale for aligning payment rates across ambulatory settings

- Address the principle that Medicare and beneficiaries should not pay more than necessary for ambulatory services
- Reduce incentives for providers to consolidate

Potential impacts of aligning payment rates are substantial

- Current law: CMS would use pool of money from aligning payment rates to increase OPPS payment rates for 101 APCs for which we would not align payment rates (ED visits, complex procedures)
- Alternatives to current law:
  - Lower program outlays and cost sharing
  - Fund temporary policies to support safety-net providers
  - Both alternatives would require Congressional action

Discussion

- Questions and comments about analysis?
- Aligning ambulatory payment rates
  - Consensus in April 2022
  - Move to draft recommendations?
- What should be done with the savings from aligning payment rates?
  - Budget neutral adjustment to OPPS payment rates (current law)
  - Use all of it as savings
  - Temporarily support safety-net providers