CHAPTER 6

Aligning fee-for-service payment rates across ambulatory settings

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Chapter summary

Medicare payment rates often differ for the same service among ambulatory settings (hospital outpatient departments (HOPDs), ambulatory surgical centers (ASCs), and freestanding physician offices). These payment differences across settings encourage arrangements among providers—such as consolidation of physician practices with hospitals—that result in care being provided in the settings with the highest payment rates, which increases total Medicare spending and beneficiary cost sharing without significant improvements in patient outcomes. From 2015 to 2019, for example, the volume of chemotherapy administration in freestanding clinician offices, the setting for which payment rates are generally lowest, fell 5.4 percent, while the volume in HOPDs, the setting for which payment rates are generally highest, climbed 27.8 percent.

In general, the Commission maintains that Medicare should base payment rates on the resources needed to treat patients in the most efficient setting. If the same service can be safely provided in different settings, a prudent purchaser should not pay more for that service in one setting than in another. Payment rate differences across the three ambulatory settings could be addressed simply by setting payment rates for a given service equal to that of the setting that has the lowest payment, which

In this chapter

is usually—but not always—freestanding offices. However, HOPDs have important differences from freestanding offices and from ASCs that can lead to higher costs in HOPDs for certain services. For example, hospitals incur costs to maintain standby capacity for handling emergencies and to comply with additional regulatory requirements that ASCs and freestanding offices do not have. Also, some services can be safely provided only in HOPDs for most beneficiaries, so it is vital that HOPDs are adequately reimbursed to remain a viable setting for the provision of those services. In addition, identifying payment rate differences among the three payment systems requires careful analysis because the outpatient prospective payment system (OPPS) and the ASC payment system generally package payment for ancillary items provided with a service, while the fee schedule for physicians and other health professionals, also known as the physician fee schedule (PFS), does not. This difference in the packaging of services must be considered when comparing payment rates among settings.

To evaluate whether an ambulatory service should continue to have different payment rates in the three settings or whether it would be appropriate to align the payment rates more closely across the three settings, we analyzed the ambulatory payment classifications (APCs) used in the OPPS to pay for services provided in HOPDs. Each APC includes a set of services that are similar in terms of clinical attributes and cost; all services included in a single APC have the same payment rate. Of the OPPS's 169 APCs for services (as opposed to drugs and devices), we identified 57 APCs for which it would be reasonable to align payment rates across the three ambulatory care settings with those of the PFS. The physician office is the most frequent site of service for these 57 APCs, indicating that freestanding offices are a safe and appropriate setting for these services and that PFS payment rates are adequate to ensure beneficiaries' access to care. We also identified 11 APCs for which ASCs have the largest volume among the three ambulatory settings. For these APCs, it would be appropriate to align the OPPS payment rates with those paid in the ASC setting, while continuing to use the PFS payment rate when the service is provided in a freestanding office. Finally, for 101 APCs, including emergency department (ED) visits, the HOPD is the most frequent setting, or the services cannot be provided in settings other than HOPDs. For these APCs, each setting should continue to have a different payment rate, with generally higher payments for HOPDs.

As policymakers consider how to align payment rates across ambulatory settings, they must ensure that hospitals continue to receive adequate financial

support to maintain standby emergency capacity. To maintain this support, the APCs for ED visits, critical care visits, and trauma care visits could be reclassified from standard APCs to comprehensive APCs (C–APCs). C–APCs are an advanced form of APC in which all services—with a few exceptions—that appear on the same claim are packaged together into a single payment unit. By transforming payment for these services from standard APCs to C–APCs, higher payment rates for the provision of services during these visits would be maintained, appropriately reflecting the hospital-level costs of items and services provided.

Some stakeholders contend that payment rates should be higher for services provided in HOPDs relative to other ambulatory settings because HOPD patients are sicker and more complex on average relative to patients in other ambulatory settings. However, we have found that patient severity has little effect on the costs incurred by HOPDs when furnishing the services in the APCs for which payment rate alignment across settings would be reasonable. Therefore, we concluded that, if payment rates were aligned, adjustments for patient severity would not be needed.

In aggregate, if changes in payments resulting from aligning payment rates were taken as program savings, Medicare program spending in 2019 would have declined by $6.6 billion and beneficiary cost-sharing obligations by $1.7 billion. Across all hospitals, a site-neutral policy would have reduced overall Medicare revenue by 4.1 percent and beneficiary OPPS cost sharing by 13.2 percent.

Under current law, CMS would be required to fully offset the lower Medicare spending and beneficiary cost sharing from aligning ambulatory payment rates by increasing the OPPS payment rates for all other (nonaligned) APCs to produce a budget-neutral result. Combining alignment of payment rates with a budget-neutrality adjustment within the OPPS would lower incentives to shift services to higher-cost settings but would reduce savings for Medicare and beneficiaries. However, if the budget-neutrality adjustment were not applied, some hospitals that are the primary source of access to physician services for low-income patients would experience reductions in Medicare revenue under the payment alignment policy, which could adversely affect access for these beneficiaries. In response to these concerns, policymakers could consider an alternative to the budget-neutrality policy that would explicitly target hospitals that serve a high share of low-income beneficiaries to limit the loss of Medicare revenue for these hospitals. Over time, the payment rate alignment

policy would produce savings for the Medicare program and lower cost sharing for beneficiaries under either the budget-neutrality policy or the stop-loss policy because incentives to shift services from the lower-cost physician office and ASC settings to the higher-cost HOPD setting would be mitigated. ■

Medicare's payment rates often vary for the same ambulatory services provided to similar patients in different settings, including freestanding physicians' offices, hospital outpatient departments (HOPDs), and ambulatory surgical centers (ASCs). These payment differences across settings encourage arrangements among providers—such as the consolidation of physician practices with hospitals—that result in care being billed at the payment rates of the provider with the highest rates, increasing program and beneficiary spending without meaningful changes in patient care.

This chapter discusses a method to more closely align payment rates across the three ambulatory care settings—HOPDs, ASCs, and freestanding offices—that is broader than Medicare's current policies. This method would move beyond the policies recently implemented by CMS and the Commission's previous recommendations in 2012 and 2014 by aligning payment rates across a greater number of services. We examine the impact of potential payment changes on Medicare spending, beneficiary cost sharing, and hospital revenue. We also discuss accompanying budget-neutrality or stop-loss policies that would mitigate the impact on hospital revenue and whether an adjustment to payments for differences in patient severity would be needed.

Background

CMS sets payment rates for clinician services in the fee schedule for physicians and other health professionals, also known as the physician fee schedule (PFS); payment rates for most HOPD services in the outpatient prospective payment system (OPPS); and payment rates for ASC services in the ASC payment system. For services provided in freestanding clinician offices, Medicare makes a single payment to the practitioner under the PFS. For services provided in HOPDs or ASCs, Medicare makes two payments: one for the clinician's professional fee under the PFS and one for the HOPD or ASC facility fee under the OPPS or ASC payment system.

Medicare payment rates for ambulatory services often differ among the three ambulatory settings and are usually highest in HOPDs. For example, in 2022, Medicare pays 141 percent more in an HOPD than in a freestanding office for the first hour of chemotherapy infusion (counting both the professional fee and facility fee). In addition, in 2022, Medicare pays 105 percent more in on-campus HOPDs than in freestanding offices for a midlevel office visit. These types of variations raise questions about how Medicare should pay for the same service when it is delivered in different settings.

Generally, the Commission has maintained that Medicare should strive to base payment rates on the resources needed to treat patients in the most efficient (meaning the highest quality, lowest cost) setting, which would mitigate incentives to shift the provision of services to higher-cost settings. In the absence of comparable data on providers' costs and quality across settings that justify payment differences, Medicare should set payment rates such that the cost to the program and beneficiaries is not higher than necessary to ensure beneficiaries' access to high-quality care. On the basis of these principles, the Commission recommended in 2012 that Medicare reduce payment rates and cost sharing for office visits provided in HOPDs and, in 2014, for services meeting certain criteria so that total payment rates and cost sharing would be equal whether these visits were provided in an HOPD or in a freestanding physician's office (Medicare Payment Advisory Commission 2014, Medicare Payment Advisory Commission 2012).

In the Bipartisan Budget Act (BBA) of 2015, the Congress directed CMS to develop a limited system that more closely aligns payment rates between HOPDs and freestanding offices. CMS satisfied this mandate in 2017 by implementing payment rates that approximate PFS rates for certain services provided in off-campus provider-based departments (PBDs) of hospitals that were not providing services when the Congress enacted the BBA of 2015 on November 2, 2015 (Centers for Medicare & Medicaid Services 2016). In 2019, CMS moved beyond the BBA of 2015 requirements by reducing the OPPS payment rate to more closely align with the PFS rate for office visits that occur in any off-campus PBD, not just those specified in the BBA of 2015 (Centers for Medicare & Medicaid Services 2019).

While CMS's policies more closely align OPPS payment rates with PFS payment rates for some services, the effects of these policies are somewhat limited. Only 0.8 percent of total OPPS spending is for services provided in off-campus PBDs covered by the BBA of

TABLE 6–1

Provision of important ambulatory services has shifted from physician offices to hospital outpatient departments

	Share in HOPDs	
Service	**2012**	**2019**
Office visits	9.6%	13.1%
Chemotherapy administration	35.2	50.9

Note: HOPD (hospital outpatient department).

Source: MedPAC analysis of 100 percent standard analytic claims files, 2012 and 2019.

2015 requirements. In addition, only one-third of the office visits provided in HOPDs occur in off-campus PBDs. Also, the off-campus PBDs not subject to the BBA of 2015 site-neutral payments have no restrictions on expanding the range of services they provide. Therefore, if a hospital acquires a physician practice and adds it to an existing off-campus PBD that is excepted from the BBA of 2015, the services furnished by that practice would be paid at full OPPS rates (with the exception of office visits covered by CMS's policy mentioned above that aligns OPPS payment rates for all office visits provided in off-campus PBDs with the PFS payment rates).

Payment rate differences across ambulatory settings cause services to shift to the highest-paid setting

Some stakeholders have argued that Medicare should pay higher rates for all services provided in HOPDs because hospitals incur costs that other settings do not to maintain 24/7 emergency care, standby capacity, access to care for low-income patients, efforts to improve care coordination, and community outreach. However, the costs for maintaining standby capacity and other hospital programs are spread across all HOPD services, including those that are unrelated to the additional hospital activities. The spreading of the costs for standby capacity across all HOPD services is part of the reason that OPPS payment rates are generally higher than PFS and ASC payment rates.

The resulting payment rate differences among the ambulatory settings provide incentives for hospitals to work out arrangements that shift the site of care from lower-paid freestanding offices and ASCs to the higher-paid HOPD setting—or that reclassify a site of care so that bills can be submitted and paid under the OPPS. Partly in response to these incentives, in recent years hospitals have acquired more physician practices, and hospital employment of physicians has increased. Analysis of data from the American Medical Association's Physician Practice Benchmark Surveys indicates that the share of physicians who were either in practices that had at least some hospital ownership or were employees of hospitals increased from 29.0 percent in 2012 to 39.8 percent in 2020 (Kane 2021).

As hospitals acquire more physician practices and more physicians become employed by hospitals, large shifts in billing from the PFS to the OPPS have occurred for four service categories: chemotherapy administration, echocardiography, cardiac imaging, and office visits. For example, the HOPD share of office visits provided to fee-for-service (FFS) beneficiaries grew from 9.6 percent in 2012 to 13.1 percent in 2019, and the HOPD share of chemotherapy administration services rose from 35.2 percent to 50.9 percent (Table 6-1). Because most services receive higher payment rates when provided in HOPDs than in freestanding

offices, migration of services from freestanding offices to HOPDs results in higher program spending and beneficiary cost sharing without meaningful changes in patient care. For example, the Commission estimates that the shift of office visits from the office setting to the HOPD setting from 2015 through 2019 increased Medicare program spending by $615 million and beneficiary cost sharing by $150 million. Program spending and beneficiary cost sharing could be reduced by more closely aligning OPPS payment rates with PFS payment rates for services that are clearly safe to provide in freestanding offices for most Medicare beneficiaries.

We are also concerned about pricing differences between the OPPS and the ASC payment system for similar services. For the OPPS, CMS creates a relative weight for each service, which indicates the resources needed to provide the service relative to a benchmark service (the office visit). CMS multiplies the relative weights by a conversion factor to create payment rates in the OPPS. For the ASC payment system, CMS bases the relative weights for most procedures on the OPPS relative weights, but the ASC system uses a lower conversion factor. Therefore, payment rates for all procedures are much higher in the OPPS. For 2022, the Medicare rates for most services are 97 percent higher in the OPPS than in the ASC system. Beneficiary cost sharing is also much higher in HOPDs than in ASCs, as coinsurance is 20 percent of the payment rate for most services in both settings. Moreover, the gap in payment rates between the two settings has widened over time.

Program spending and beneficiary cost sharing could be reduced by more closely aligning OPPS payment rates with ASC payment rates for services that are clearly safe to provide in ASCs for most Medicare beneficiaries.

HOPDs incur costs that are unique to that setting

Payment rate differences between the OPPS, the PFS, and the ASC payment system could be addressed simply by setting payment rates equal across the three settings. There are precedents for this approach: Medicare pays the same amount for outpatient therapy services, mammography tests, dialysis services, and clinical lab tests regardless of setting. In addition, CMS sets the payment rate for some services provided in ASCs at the nonfacility practice expense rate from the PFS.

However, HOPDs have important differences from freestanding offices and ASCs that can lead to higher costs in HOPDs for certain services:

- Hospitals incur costs to maintain standby capacity for handling emergency care. They are subject to the Emergency Medical Treatment and Active Labor Act of 1986 (EMTALA), which requires them to screen and stabilize (or transfer) patients who believe they are experiencing a medical emergency, regardless of their ability to pay.
- Hospitals face a unique set of licensing and accreditation requirements that increase their cost structure. Hospitals must meet conditions of participation in the Medicare program, which adds to their costs; these conditions do not apply to ASCs or freestanding offices.
- Hospitals must comply with more stringent building codes and life-safety codes. Also, an outpatient facility that is considered part of a hospital must meet CMS's rules for provider-based status, such as maintaining financial integration with the parent hospital.[1] These rules could result in higher costs for providers, Medicare, and beneficiaries, without evidence that patient care has improved.

A final issue to consider when aligning payment rates across ambulatory settings is whether patients in some settings are sicker than others, as it can be more costly to provide the same service to sicker patients than to healthier patients. The American Hospital Association (AHA) has argued that patients in HOPDs tend to be more medically complex than patients who receive the same type of service in an ASC or freestanding office (American Hospital Association 2021). This finding from the AHA suggests that treating these patients may require more time and resources. As discussed later in this chapter, however, Commission analysis has found only a weak relationship between beneficiaries' health status and HOPD charges.

Some may argue that the requirements that apply to hospitals but do not apply to ASCs or freestanding offices are a reason for maintaining higher OPPS

payment rates for all services provided in HOPDs. However, the additional requirements faced by HOPDs are a reason to encourage less provision in HOPDs of services that are clearly safe to provide in freestanding offices or ASCs. The additional requirements faced by HOPDs help to ensure safe provision of services that can be provided only in HOPDs, such as emergency department (ED) visits, or that are too complex to reasonably provide in the other settings, such as many joint replacement procedures. These additional requirements faced by hospitals are not needed to ensure safe provision of less complex services that can be safely provided in lower-cost settings, such as office visits or the administration of most drugs. A prudent purchaser of care would encourage provision of the less complex services in the lowest-cost setting where it is reasonable to do so. More closely aligning OPPS payment rates with PFS rates or ASC rates for services that are reasonable to provide in the other ambulatory settings is an efficient way to do so. Aligning OPPS payment rates with the payment rates in the lower-cost settings for the less complex services would reduce spending by the Medicare program and beneficiary cost-sharing liabilities.

Identifying services for which payments can be more closely aligned across settings

While more closely aligning the payment rates across ambulatory settings is beneficial, ensuring beneficiaries' access to the services they need is vital. To ensure beneficiaries' access to care, several issues need to be addressed:

- As discussed above, hospitals incur costs to maintain standby capacity and licensing and accreditation.
- The services subject to payment alignment must be safe to provide to most beneficiaries in the lower-cost setting.
- The differences between payment systems in the packaging of ancillary items must be accounted for. Specific differences in packaging ancillary items between payment systems include the following:
  - In general, the OPPS and ASC payment system use the same method of combining the cost of primary services with ancillary items into a single payment bundle. In contrast, the PFS has less packaging of ancillary items, and Medicare tends to pay separately for each item. Therefore, for many services, some portion of the higher payment rates under the OPPS and the ASC system relative to PFS rates reflects a greater level of packaging.
  - The PFS uses 90-day global codes for some surgical procedures, while the OPPS and the ASC payment system do not. The PFS payments for 90-day global surgical codes include the surgical procedure itself and office visits that occur within a 90-day period after the procedure. The PFS payment rates for these services also include the cost of staff time spent scheduling the procedure and coordinating presurgical services when the procedure is performed in a facility (rather than an office).

To identify services for which it is reasonable to more closely align payment rates across ambulatory settings, we took the following steps:

- We sorted services into ambulatory payment classifications (APCs), which are the payment classifications used in the OPPS. APCs are made up of services represented by Healthcare Common Procedure Coding System (HCPCS) codes. CMS classifies HCPCS codes that are similar in terms of cost and clinical attributes in the same APC. All HCPCS codes in the same APC have the same OPPS payment rate.
- Some APCs include services that can be reasonably provided only in HOPDs, such as emergency care, critical care, and trauma care. We removed these APCs from consideration.
- For the remaining APCs, we compared the volume of services provided in HOPDs, ASCs, and freestanding offices over a four-year period (2016 through 2019).
  - If freestanding offices had the highest volume for an APC, we determined that the services in that APC could be safely provided in freestanding offices for most beneficiaries and

that beneficiaries would be able to access the services in that APC. Therefore, it would be reasonable to align the OPPS and ASC payment rates more closely with the PFS payment rates for those services.

- If ASCs had the highest volume for an APC, we determined that the services in that APC could be safely provided in ASCs for most beneficiaries. Therefore, the OPPS payment rates could be aligned more closely with the ASC payment rates for those services. Freestanding offices would still be paid PFS rates for those services.
- If HOPDs had the highest volume for an APC, it might not be safe to provide those services outside the HOPD setting for most Medicare beneficiaries. In addition, we would be concerned about beneficiaries' access to those services if HOPD payments were aligned with either PFS or ASC payment rates. We therefore determined that, for these APCs, HOPDs should continue to be paid OPPS payment rates, ASCs should continue to be paid ASC payment rates, and freestanding offices should continue to be paid PFS rates.

Services for which differential payment rates should continue

The OPPS has 169 APCs for services provided in HOPDs.[2] Some of these service APCs represent emergency care, critical care, trauma care, and observation care, which can be provided only in HOPDs. For some additional APCs, volume is higher in HOPDs than in the other two ambulatory settings. Because these services are predominantly provided in HOPDs and tend to represent complex services, the current OPPS payment rates should continue to be paid when they are provided in HOPDs. Overall, we identified 101 APCs for which payment rates should not be aligned across ambulatory settings. For these APCs, services provided in HOPDs should continue to be paid at OPPS rates, services provided in ASCs should continue to be paid at ASC rates, and services provided in freestanding offices should continue to be paid at PFS rates. Combined Medicare spending and beneficiary cost sharing under the OPPS for these APCs was $34 billion in 2019.

Services for which alignment of OPPS and ASC payment rates with PFS payment rates is reasonable

Of the 169 APCs examined, we identified 63 APCs for which the volume of services provided in each year from 2016 through 2019 was highest in freestanding offices. However, six of these APCs have a substantial amount of packaging under the OPPS, and in these six APCs, some of the HCPCS codes have low volume in freestanding offices and high volume in HOPDs. We have reservations about aligning OPPS and ASC payments rates with PFS payment rates for these APCs. Therefore, we determined that it would be appropriate to maintain differential payment rates for these six APCs.

For the remaining 57 APCs, it would be reasonable to more closely align OPPS and ASC payment rates to PFS payment rates. These APCs constitute 71 percent of Medicare volume and 22 percent of Medicare revenue for services covered under the OPPS and constitute 28 percent of Medicare volume and 11 percent of Medicare revenue for services covered under the ASC system. In Table 6-2 (pp. 170–171), we list the OPPS volume, OPPS Medicare spending, and beneficiary cost sharing from 2019 for these 57 APCs. In general, the services in these 57 APCs are of lower complexity than the average APC—that is, they require comparatively fewer resources. The average OPPS payment rate for these 57 APCs is $149, much lower than the average OPPS payment rate of $381 for all service APCs.

Aligning payment rates across three ambulatory settings

When a physician provides a service in a freestanding office, ASC, or HOPD, the physician's payment under the PFS has three components: physician work, practice expense (PE), and professional liability insurance (PLI). The work and PLI payments are the same in all settings. However, the PE payment for a service provided in a freestanding office (the "nonfacility" PE) is usually higher than the PE payment for a service provided in an ASC or HOPD (the "facility" PE). The higher nonfacility PE payment reflects the cost of clinical staff, medical equipment, medical supplies, and additional overhead incurred by the physician. Therefore, for most services, the total payment received by clinicians under the PFS is higher in a freestanding office than in the other two settings.

TABLE 6–2

Program spending, beneficiary cost sharing, and volume for 57 APCs for which alignment of OPPS payment rates with PFS payment rates is reasonable, 2019

APC	APC description	Program spending (in millions)	Beneficiary cost sharing (in millions)	Volume (in thousands)
5012	Clinic visits	$3,029	$757	32,685
5693	Level 3 drug administration	976	244	6,521
5522	Level 2 imaging w/o contrast	765	191	8,501
5524	Level 4 imaging w/o contrast	738	185	1,855
5593	Level 3 nuclear medicine	685	171	696
5523	Level 3 imaging w/o contrast	643	161	3,486
5694	Level 4 drug administration	580	145	2,516
5521	Level 1 imaging w/o contrast	441	110	8,852
5691	Level 1 drug administration	330	82	10,879
5724	Level 4 diagnostic tests and related services	296	74	406
5373	Level 3 urology and related services	278	70	200
5443	Level 3 nerve injections	249	62	423
5052	Level 2 skin procedures	243	61	1,106
5442	Level 2 nerve injections	234	58	506
5054	Level 4 skin procedures	226	56	202
5692	Level 2 drug administration	200	50	4,178
5441	Level 1 nerve injections	180	45	959
5822	Level 2 health and behavior services	161	40	2,643
5611	Level 1 therapeutic radiation treatment preparation	146	51	1,592
5722	Level 2 diagnostic tests and related services	152	38	754
5051	Level 1 skin procedures	112	28	890
5734	Level 4 minor procedures	82	20	963
5071	Level 1 excision/biopsy/incision and drainage	76	19	170
5733	Level 3 minor procedures	75	19	1,672
5723	Level 3 diagnostic tests and related services	73	18	199
5823	Level 3 health and behavior services	71	18	698
5372	Level 2 urology and related services	69	17	155
5053	Level 3 skin procedures	66	17	208
5721	Level 1 diagnostic tests and related services	62	15	568
5153	Level 3 airway endoscopy	56	14	51
5101	Level 1 strapping and cast application	47	12	538
5671	Level 1 pathology	35	9	857
5371	Level 1 urology and related services	29	7	163
5164	Level 4 ENT procedures	28	7	15
5741	Level 1 electronic analysis of devices	26	7	886
5055	Level 5 skin procedures	26	6	12
5481	Laser eye procedures	24	6	62

TABLE 6-2

Program spending, beneficiary cost sharing, and volume for 57 APCs for which alignment of OPPS payment rates with PFS payment rates is reasonable, 2019 *(cont.)*

APC	APC description	Program spending (in millions)	Beneficiary cost sharing (in millions)	Volume (in thousands)
5151	Level 1 airway endoscopy	19	5	147
5732	Level 2 minor procedures	16	4	634
5111	Level 1 musculoskeletal procedures	12	3	67
5743	Level 3 electronic analysis of devices	9	2	39
5163	Level 3 ENT procedures	9	2	9
5102	Level 2 strapping and cast application	8	2	47
5161	Level 1 ENT procedures	8	2	51
5152	Level 2 airway endoscopy	7	2	22
5411	Level 1 gynecologic procedures	4	1	34
5162	Level 2 ENT procedures	4	1	10
5413	Level 3 gynecologic procedures	4	1	9
5412	Level 2 gynecologic procedures	4	1	18
5821	Level 1 health and behavior services	3	1	127
5501	Level 1 extraocular, repair, and plastic eye procedures	3	1	13
5742	Level 2 electronic analysis of devices	3	1	29
5502	Level 2 extraocular, repair, and plastic eye procedures	3	1	4
5621	Level 1 radiation therapy	1.7	0.4	19
5731	Level 1 minor procedures	0.8	0.2	56
5735	Level 5 minor procedures	0.6	0.1	2
5811	Manipulation therapy	0.5	0.1	26

Note: APC (ambulatory payment classification), OPPS (outpatient prospective payment system), PFS (physician fee schedule), ENT (ear, nose, and throat). Program spending indicates outlays by the Medicare program under the OPPS and excludes beneficiary cost sharing. For all APCs listed, "beneficiary cost sharing" is 25 percent of "program spending" except for APC 5194, for which the beneficiary copayment is capped at the deductible amount under the inpatient prospective payment system, and APC 5611, for which the beneficiary copayment is 35 percent of the payment to the provider.

Source: MedPAC analysis of 100 percent standard analytic claims files from 2019 and MedPAC analysis of payment rates in the 2019 OPPS.

However, for services provided in an ASC or HOPD, Medicare makes an additional payment to the ASC under the ASC system or to the hospital under the OPPS to cover the costs of the clinical staff, medical equipment, medical supplies, and overhead incurred by the facility. In most cases, the PFS payment for a service provided in a freestanding office is lower than the combined PFS and ASC payments or combined PFS and OPPS payments for a service delivered in an ASC or HOPD. For example, when a service from APC 5442 (level 2 nerve injections) was provided in a freestanding office in 2019, the payment to the physician equaled the sum of the physician work, PLI, and nonfacility PE payments, which totaled $256.28 (Table 6-3, p. 172). If the service was provided in an HOPD, the payment equaled the sum of the work, PLI, and facility PE payments, plus the OPPS payment, for a total of $701.16.

TABLE 6–3

Differences in Medicare payment rates for level 2 nerve injection provided in physician's office or HOPD, 2019

Actual 2019 payment rates		Policy that would align rates across settings	
Service in physician's office		***Service in physician's office***	
Physician work	$64.87	Physician work	$64.87
Nonfacility PE	$185.64	Nonfacility PE	$185.64
Professional liability insurance	+ $5.77	Professional liability insurance	+ $5.77
Total payment	**$256.28**	**Total payment**	**$256.28**
Service in HOPD		***Service in HOPD***	
Physician work	$64.87	Physician work	$64.87
Facility PE	$31.71	Facility PE	$31.71
Professional liability insurance	+ $5.77	Professional liability insurance	+ $5.77
Payment to physician	$102.35	Payment to physician	$102.35
Payment to HOPD (OPPS rate)	+ $598.81	Payment to HOPD (nonfacility PE – facility PE)	+ $153.93
Total payment	**$701.16**	**Total payment**	**$256.28**

Note: HOPD (hospital outpatient department), PE (practice expense), OPPS (outpatient prospective payment system). Payments include both program spending and beneficiary cost sharing.

Source: MedPAC analysis of physician fee schedule and OPPS payment rates for 2019.

However, the payment rates for this service could be more closely aligned across settings if CMS replaced the existing OPPS and ASC payment rates with rates based on the differences between the nonfacility PE rate and the facility PE rates in the PFS.[3] Making this adjustment would drop the HOPD payment to $153.93, and the total payment would fall to $256.28, the same rate paid in a freestanding office. (The difference between the payment rates for freestanding offices and ASCs would be smaller: Total payment when this service was provided in ASCs in 2019 was $402.82.)

Note that all of the 57 APCs where payment rates could be more closely aligned have more than one HCPCS code, and all HCPCS codes within an APC have the same payment rate under the OPPS and the ASC system. In contrast, the PFS has separate payment rates for each HCPCS code. When we aligned the OPPS and ASC payment rates with the PFS rates for an APC, we used a weighted average of the payment rates from the PFS for the HCPCS codes in that APC, using the volume for the HCPCS codes as the weights. We multiplied the weighted average of the differences in the nonfacility PE and facility PE payment by the PFS conversion factor to obtain a base rate for the APC.

However, because the policies for packaging ancillary items differ among the PFS, OPPS, and ASC system, we could not rely strictly on the average differences between nonfacility and facility PEs to accurately align payment rates for all 57 APCs. To adjust for the greater packaging of ancillary items in the OPPS and ASC system relative to the PFS, for each of the 57 APCs, we used data from OPPS hospitals to estimate the share of the cost of the services in the APCs that was attributable to packaged ancillary items.[4] To determine the payment rate for services provided in HOPDs and ASCs, we multiplied the base rate for the APC by the share of costs that was attributable to ancillary items.

For example, APC 5012 (the APC for clinic visits) had an average difference between the nonfacility PE and facility PE of $29.37 (the base rate). We found that, when the services in this APC were provided in HOPDs, the average cost of these services was $120.74 and the average cost of the ancillary items packaged with them was $31.84, for an average cost of $152.58 ($120.74 + $31.84). The cost of the packaged items added 26.4 percent to the total cost of the service, and we applied this percentage to the base rate of $29.37. Therefore, the payment rate for aligning OPPS rates with PFS rates for APC 5012 would be $29.37 × 1.264 = $37.12.

A second adjustment that must be addressed for packaging differences across payment systems relates to the 90-day global bundles used in the PFS but not in the ASC system or OPPS. The 90-day global bundles include the surgical procedure itself and office visits that occur within a 90-day period after the procedure. In addition, CMS assumes that the physician's staff spends time scheduling the procedure and coordinating presurgical services when the procedure is performed in a hospital or ASC. This scheduling and coordination is not necessary when the services are provided in a physician's office. Therefore, these services are assumed to have a higher cost when delivered in an HOPD or ASC. For the instances in which a HCPCS code has a 90-day global bundle under the PFS, we chose to use the PFS nonfacility PE alone rather than the difference between the nonfacility PE and the facility PE in the calculation of APC base rates. Use of the nonfacility PE rates alone for this purpose is not unprecedented. CMS used the nonfacility PE rates for some HCPCS codes in its method to align OPPS payment rates for services provided in off-campus PBDs with PFS rates to satisfy requirements in Section 603 of the BBA of 2015 (Centers for Medicare & Medicaid Services 2019).

An example of our process for aligning OPPS and ASC payment rates with PFS payment rates is APC 5151 (level 1 airway endoscopy). From 2016 through 2019, about 90 percent of the volume for APC 5151 was provided in freestanding offices, so this service is a clear candidate for payment rate alignment. The average weighted sum of the difference between the nonfacility PEs and facility PEs for the HCPCS codes in APC 5151 is 2.59.[5] We multiplied that weighted average by the PFS conversion factor ($36.04) to obtain a base rate of $93.19. We have also found that packaged items add 4.3 percent to the HOPD costs for the services in APC 5151. We multiplied that percentage by the base rate to obtain a payment rate for APC 5151 of $97.17.

Considering the need for a patient-severity adjustment

After identifying the APCs that we deemed appropriate for payment rate alignment, we considered whether aligned payments should be adjusted for differences in patient severity. Analysis sponsored by the American Hospital Association suggests that patients receiving care in HOPDs are more medically complex than those receiving care in freestanding offices (American Hospital Association 2021). Subsequently, we evaluated risk scores from the CMS–hierarchical condition category (HCC) risk-adjustment model to compare the medical complexity of HOPD patients with patients in freestanding offices. The results indicate that HOPD patients have higher average risk scores. Greater patient complexity in HOPDs relative to physician offices suggests that adjusting for patient severity could be warranted.

However, we also found substantial overlap in the CMS–HCC risk scores of patients in these two settings. In most APCs, the median CMS–HCC risk score among HOPD patients falls between the median and 75th percentile of CMS–HCC risk scores among patients in freestanding offices. Moreover, most of the APCs for which it is reasonable to align OPPS payment rates with PFS payment rates represent low-complexity services, so patient acuity might have little effect on the resources needed to provide these services. Indeed, before 2014, the OPPS had five APCs for office visits, which represented 10 HCPCS codes. To some extent, these five APCs distinguished patients by complexity. In 2014, however, CMS combined the five APCs into a single APC for all office visits. One of CMS's arguments for combining the five APCs into one APC was that variation in resources needed to provide office visits was not large enough to warrant five different APCs and payment rates. Notably, researchers at RAND found that differences in patient clinical characteristics did not support payment differences across ambulatory settings (Wynn et al. 2011).

The uncertainty over whether it would be necessary to adjust aligned payment rates for differences in patient severity led us to evaluate the extent to which hospital

Analyzing the effect of patient severity on charges for services provided in hospital outpatient departments

The Commission used regression analysis to estimate the relationship between patient severity and the hospital charges for services provided in hospital outpatient departments (HOPDs). We used the beneficiary's Charlson comorbidity index (CCI) as a measure of patient severity, which is an index that represents a patient's health. The CCI is based on the patient's age and whether the patient has any of these 19 conditions: myocardial infarction, congestive heart failure, peripheral vascular disease, cerebrovascular disease, dementia, chronic pulmonary disease, rheumatic disease, peptic ulcer disease, mild liver disease, diabetes without chronic complication, diabetes with chronic complication, hemiplegia or paraplegia, renal disease (mild to moderate), renal disease (moderate to severe), any malignancy (except malignant neoplasm of skin), moderate to severe liver disease, metastatic solid tumor, HIV infection (no AIDS), and AIDS. Each age category and each condition has a weight. A patient's CCI is the sum of the weight from their age category and the weights from the applicable conditions. A beneficiary's CCI can range from 0 to 36.

Our analysis examined the 57 ambulatory payment classifications (APCs) for which it is reasonable to align Medicare payment rates across the 3 ambulatory settings for patient care. To ensure that we had enough observations to produce reliable

(continued next page)

charges are affected by patient severity in the APCs for which it is reasonable to align payment rates. To measure the relationship between charges and patient severity, we performed a regression for each of the 22 APCs that have enough records to provide statistically reliable results. In these analyses, we used hospital charges for providing a service to a beneficiary as the dependent variable and used the following explanatory variables:

- sex of the beneficiary who received the service,
- a dichotomous indicator (0 or 1) for whether the beneficiary had full dual-eligibility status,[6]
- an indicator for the hospital that provided the service, and
- the beneficiary's Charlson comorbidity index (CCI) to account for the beneficiary's health status (Charlson et al. 1987, Glasheen et al. 2019, Quan et al. 2005).

We included an indicator for the hospital providing the service because charging practices vary by hospital, especially in the extent to which hospitals mark up charges above costs (for more details, see the text box on patient severity and charges for services).

For each of the 22 APCs that we evaluated, we used the results from the regressions to estimate the percentage change in charges corresponding to a 10 percent increase in the average CCI score. We found that for the APC for which charges were most responsive to a change in the CCI, a 10 percent increase in the CCI was associated with a 0.9 percent increase in charges. In summary, the results from these regressions indicate that the level of a beneficiary's CCI typically has a small effect on the claim charges.

In addition to our finding of a weak relationship between a beneficiary's health status (as measured by the CCI) and hospital charges, we identified four additional arguments that call into question the need for a patient-severity adjustment under a payment rate alignment policy:

Analyzing the effect of patient severity on charges for services provided in hospital outpatient departments (cont.)

results, we limited our analysis to the 22 APCs that had the most claims suitable for this analysis. These APCs constitute about $13 billion in Medicare spending under the outpatient prospective payment system (OPPS). For each APC, we identified the claims covered under the OPPS that had services that matched to the APC. For each of these claims, we determined the hospital charges for the service and the charges for the ancillary items packaged with the service under the OPPS packaging rules to create the total charges for the service and the packaged ancillary items that form the unit of payment under the OPPS. For example, if during an HOPD visit for chemotherapy administration the patient also has a complete metabolic panel and a complete blood count (CBC), the chemotherapy is the service and the metabolic panel and CBC are ancillary items, and these three items are packaged into a single unit for payment under the OPPS. For this analysis, we summed the charges for the three items to create a total charge for the service.

We collected the charges for the services and their bundled ancillary items into the APCs of the services. For each APC, we performed the regressions using the dependent variable (the charges for the service and the packaged ancillary items) and four explanatory variables, which include an identifier for the hospital that provided the service, whether the beneficiary had full Medicaid benefits, the beneficiary's sex, and the beneficiary's CCI. ■

- During a patient visit to an HOPD, the provider can furnish more than one service for which they can bill under the OPPS. The structure of the OPPS contrasts with payment systems that have adjustments for patient severity—such as the inpatient prospective payment system (IPPS)—or for which adjustments for patient severity would be beneficial, such as the skilled nursing facility payment system. In these payment systems, the unit of payment is much broader relative to the OPPS. For example, the unit of payment for the IPPS is the inpatient stay. All services provided during an inpatient stay are covered under a single payment unit, with allowances for higher payments based on patient severity. Under the OPPS, if a relatively complex patient requires more intensive care or a more costly drug than a less complex patient for the same type of visit, the hospital is often able to bill for the additional care or more costly drug as covered under the OPPS.
- Most of the 57 APCs suitable for payment rate alignment represent low-complexity services—office visits, X-rays, minor procedures, and drug injections are common. For these services, patient complexity may have little effect on the resources needed to provide the service.
- CMS has grouped the 169 service APCs into hierarchies; each level within a hierarchy represents a different level of resources needed to provide a service. For example, the OPPS has four APCs for imaging without contrast—level 1 through level 4. Under this construct, providers may be able to code more complex patients to higher-level APCs, for which the providers receive a higher payment.
- The services in many of the 57 APCs suitable for payment rate alignment are overwhelmingly provided in physician offices. For example, for 13 of the APCs, more than 90 percent of the volume occurs in offices, suggesting that, for these APCs,

the PFS payment rates are adequate for patients of any complexity. In these situations, adjustments for patient complexity are not needed.

Based on our finding of a weak relationship between beneficiaries' health status and HOPD charges and the arguments discussed in this section, we concluded that adjustments for patient severity are not needed in aligning payment rates across ambulatory settings.

Supporting HOPDs' standby capacity A final concern about payment rate alignment for these 57 APCs is that these services are sometimes provided during ED visits. When these services are provided as part of an ED visit, the payments hospitals receive for them support the hospitals' standby and emergency capacity. Aligning the payment rates for these APCs with the typically lower PFS rates would reduce the revenue supporting the standby and emergency capacity. In the Commission's previous work on site-neutral payments, we addressed this issue by excluding from the site-neutral payments any APC for which the services within the APC were billed more than 10 percent of the time with an ED visit (Medicare Payment Advisory Commission 2013). However, the 10 percent threshold was not based on any empirical result, and we could have used a different cut point. Also, this approach eliminated from our site-neutral assessment APCs that were otherwise reasonable to include.

An alternative approach to maintain support for hospitals' standby capacity is to change the APCs for ED visits, critical care visits, and trauma care visits from standard APCs to comprehensive APCs (C–APCs). C–APCs are an advanced form of APC in which all services—with a few exceptions—that appear on the same claim are packaged together into a single payment unit. Before CMS included C–APCs in the OPPS in 2015, the OPPS provided separate payments for all separately payable services that appeared on the same claim. Under C–APCs, a claim has one separately payable service, and other services that would otherwise be separately paid under the OPPS are packaged items. Designating the APCs for ED visits as C–APCs would combine all the services provided during an emergency visit into a single payment unit. The costs of all of the services and supplies provided during ED visits would be reflected in the OPPS payment rates for ED visits. This includes the services that would otherwise be paid at the site-neutral rates. Under this approach, when a service from one of the 57 APCs for which it is reasonable to align payment rates across the three ambulatory settings is provided with an ED visit, the cost of that service would be packaged into the payment for the ED visit. When the service is provided separately from an ED visit, it would be paid at the aligned payment rate. Also, the flow of revenue supporting the hospitals' standby and emergency capacity would not be diminished by aligning payments across ambulatory settings.

Effects of aligning payment rates across three ambulatory settings

We modeled the effects of aligning payment rates for the 57 APCs for which OPPS and ASC payment rates could be based on PFS payment rates. We modeled the effects for a single year, 2019, and did not model a transition or any behavioral changes on the part of providers. To estimate the magnitude of the impact of these changes, we also ignored the current statutory requirements, discussed below, that adjustments to the OPPS relative weights must be budget neutral relative to current OPPS expenditures.

For some APCs, the reduction in beneficiary cost sharing and savings to the Medicare program would be substantial. We recognize that most beneficiaries in FFS Medicare have some form of supplemental coverage, so most of the reduced cost sharing would not result in smaller direct outlays from beneficiaries to providers. However, lower cost-sharing liabilities would result in lower beneficiary premiums for both supplemental insurance and Part B coverage.

Effects of aligning payment rates on spending and cost sharing within the OPPS In aggregate, payment rate alignment for the 57 APCs, in the absence of a budget-neutrality adjustment, would reduce beneficiary cost sharing under the OPPS by $1.4 billion and Medicare outlays by $5.5 billion.[7] Clinic visits (APC 5012) would have the largest reduction in beneficiary cost sharing and program spending (Table 6-4); beneficiary cost sharing would decline by more than $300 million, and program spending would decrease by $1.4 billion. Two APCs would have small increases in cost sharing and program spending under the OPPS (level 1 musculoskeletal procedures and level 1 minor

TABLE 6–4

Impact of aligning payment rates across three ambulatory settings: APCs with the largest and smallest reductions in beneficiary cost sharing and program outlays, 2019

		Change (in millions)	
APC	APC description	Program spending	Beneficiary cost sharing
5 APCs with largest reduction			
5012	Clinic visits	–$1,379	–$339
5524	Level 4 imaging without contrast	–508	–129
5694	Level 4 drug administration	–375	–97
5724	Level 4 diagnostic tests and related services	–281	–71
5522	Level 2 imaging without contrast	–232	–61
5 APCs with smallest (or no) reduction			
5742	Level 2 electronic analysis of devices	–0.4	–0.1
5811	Manipulation therapy	–0.4	–0.1
5502	Level 2 extraocular, repair, and plastic eye procedures	0.0	0.0
5731	Level 1 minor procedures	1.0	0.3
5111	Level 1 musculoskeletal procedures	2.1	0.5

Note: APC (ambulatory payment classification). "Program spending" indicates outlays by the Medicare program and excludes beneficiary cost sharing. Positive values indicate increases in program spending and beneficiary cost sharing.

Source: MedPAC analysis of 100 percent standard analytic claims files from 2019 and MedPAC analysis of payment rates in the 2019 physician fee schedule and outpatient prospective payment system.

procedures), as aligning OPPS payment rates with PFS payment rates would increase the OPPS rates for these APCs.

For all OPPS hospitals (the OPPS excludes critical access hospitals (CAHs) and Maryland hospitals), changing the payment rates for the 57 APCs would reduce overall Medicare revenue—which includes hospitals' Medicare revenue for all service lines (inpatient, outpatient, post-acute care)—by 3.4 percent and Medicare OPPS revenue by 10.4 percent. In addition, beneficiary OPPS cost-sharing liabilities would decrease by 11.0 percent.

Effects of aligning payment rates on spending and cost sharing within the ASC payment system Aligning the ASC payment rates with the PFS payment rates for the 57 APCs would reduce beneficiary cost sharing under the ASC payment system by $60 million and Medicare outlays by $230 million. This reduction in spending and cost sharing under the ASC system would reduce aggregate ASC Medicare revenue by 5.5 percent. While this policy would lower ASCs' total Medicare revenue by a larger percentage compared with the percentage for hospitals' total Medicare revenue (5.5 percent for ASCs vs. 3.4 percent for hospitals), the effect on ASCs' Medicare revenue would be much smaller than on the hospitals' OPPS revenue (5.5 percent in ASCs vs. 10.4 percent in HOPDs). This discrepancy between ASCs and HOPDs would occur because services provided in HOPDs and freestanding offices overlap more than services provided in ASCs and freestanding offices. In particular, office visits are frequently provided in both freestanding offices and HOPDs, but office visits are not covered under the ASC system. In addition, HOPDs

TABLE 6–5

Program spending, cost sharing, and volume for 11 APCs for which we aligned OPPS payment rates with ASC payment rates, 2019

APC	APC description	Program spending (in millions)	Beneficiary cost sharing (in millions)	Volume (in thousands)
5312	Level 2 lower GI procedures	$787	$204	1,012
5491	Level 1 intraocular procedures	651	169	428
5311	Level 1 lower GI procedures	274	27	405
5492	Level 2 intraocular procedures	222	57	77
5431	Level 1 nerve procedures	204	53	158
5112	Level 2 musculoskeletal procedures	100	26	96
5116	Level 6 musculoskeletal procedures	83	8	6
5503	Level 3 extraocular, repair, and plastic eye procedures	51	13	36
5504	Level 4 extraocular, repair, and plastic eye procedures	14	4	6
5494	Level 4 intraocular procedures	1	0	0.1
5493	Level 3 intraocular procedures	1	0	0.1

Note: APC (ambulatory payment classification), OPPS (outpatient prospective payment system), ASC (ambulatory surgical center), GI (gastrointestinal). Program spending indicates outlays by the Medicare program under the OPPS and excludes beneficiary cost sharing.

Source: MedPAC analysis of 100 percent standard analytic claims files from 2019 and MedPAC analysis of payment rates in the 2019 OPPS.

provided services in each of the 57 APCs included in our analysis, but ASCs provided services in only 39 of these APCs.

Services for which OPPS payment rates should be aligned with ASC payment rates

We identified 11 APCs for which the ASC setting has the highest volume among the ambulatory settings. Because ASCs focus on ambulatory surgical procedures, these 11 APCs represent surgical procedures including musculoskeletal, lower gastrointestinal, nerve, and ophthalmologic procedures. For these APCs, an alignment of OPPS payment rates with the ASC payment rates would be appropriate. When these services are provided in freestanding offices, the PFS payment rates would continue to apply.

Because ASC payment rates on average are nearly 50 percent lower than OPPS payment rates, aligning the OPPS payment rates with the ASC payment rates for these services would reduce OPPS spending for these services by nearly 50 percent. For example, the service provided to Medicare FFS beneficiaries most frequently in ASCs is cataract removal with intraocular lens insertion. The ASC payment rate for this service is $977, while the OPPS payment rate is $1,917.

Access to care is an issue when considering a payment rate alignment. Although the number of Medicare-certified ASCs (more than 5,900) is greater than the number of hospitals that provide outpatient services (about 4,900, including CAHs), ASCs are more geographically concentrated, so beneficiaries in some areas who have access to hospital outpatient services could have difficulty accessing ASC services. If hospitals reduce the provision of the services in these 11 APCs in response to payment rate alignment, access to these services could become difficult in areas that lack ASC presence. Most rural areas and some states (especially Vermont) could be particularly vulnerable. For example, two ASCs are located in Vermont, and

TABLE 6–6

Aligning OPPS payment rates with ASC payment rates would reduce program spending and cost sharing for 11 APCs, 2019

		Change (in millions)	
APC	APC description	Program spending	Beneficiary cost sharing
5312	Level 2 lower GI procedures	–$384.6	–$96.2
5491	Level 1 intraocular procedures	–318.3	–80.0
5311	Level 1 lower GI procedures	–132.9	–13.5
5492	Level 2 intraocular procedures	–105.5	–26.3
5431	Level 1 nerve procedures	99.9	–25.0
5112	Level 2 musculoskeletal procedures	–46.8	–11.7
5503	Level 3 extraocular, repair, and plastic eye procedures	–25.3	–6.3
5116	Level 6 musculoskeletal procedures	–16.8	–1.7
5504	Level 4 extraocular, repair, and plastic eye procedures	–6.9	–1.7
5494	Level 4 intraocular procedures	–0.7	–0.2
5493	Level 3 intraocular procedures	–0.2	0.0
	Total	–1,138	–263

Note: OPPS (outpatient prospective payment system), ASC (ambulatory surgical center), APC (ambulatory payment classification), GI (gastrointestinal). "Program spending" indicates outlays by the Medicare program and excludes beneficiary cost sharing. This table reflects the effects of aligning OPPS payment rates with ASC payment rates for 11 APCs, assuming no budget-neutrality adjustment within the OPPS.

Source: MedPAC analysis of 100 percent standard analytic claims files from 2019 and MedPAC analysis of payment rates in the 2019 ASC payment system and OPPS.

both are in the Burlington area. In contrast, Vermont has seven OPPS hospitals and nine CAHs, located throughout the state. However, it is not clear whether hospitals would respond to the ASC-aligned payment rates by substantially reducing the provision of these services.

Effects of aligning OPPS payment rates with ASC payment rates

Aligning OPPS payment rates with ASC payment rates would be less complicated than aligning OPPS payment rates with PFS payment rates because the ASC system and the OPPS have largely the same packaging policies and payment units. Our method for aligning HOPD and ASC payment rates for the 11 APCs involved calculating a weighted average of the ASC payment rates across the HCPCS codes in each APC. We used the volume for the HCPCS codes as the weights. For example, the weighted average of the ASC payment rates for APC 5491 (level 1 intraocular procedures) is $977.16.

In Table 6-5, we list the OPPS volume, OPPS Medicare spending, and beneficiary cost sharing from 2019 for these 11 APCs. In 2019, OPPS spending (program outlays and cost sharing) for the services included in the 11 APCs totaled $2.9 billion. We estimated that combined Medicare program spending and beneficiary cost sharing would decrease by $1.4 billion if the OPPS payment rates were aligned with the ASC payment rates for these 11 APCs, assuming no budget-neutrality adjustment, and beneficiaries would continue to have the same access to these services (Table 6-6). We estimated that program spending

would decrease by $1.1 billion and beneficiary cost sharing by $0.3 billion.

Under an alignment, the revised payment rates for the 11 APCs would reduce OPPS hospitals' overall Medicare revenue by 0.7 percent, Medicare outpatient revenue by 2.1 percent, and beneficiary cost sharing on OPPS services by 2.3 percent.

Combined effects of aligning payment rates on hospitals' Medicare revenue and beneficiary cost sharing

We evaluated the combined effects of a payment rate alignment between OPPS and PFS rates and between OPPS rates and ASC rates.

In aggregate, if changes in payments resulting from aligning payment rates were taken as program savings, Medicare program spending in 2019 would have declined by $6.6 billion and beneficiary cost-sharing obligations by $1.7 billion. Across all hospitals, a site-neutral policy would have reduced overall Medicare revenue by 4.1 percent and beneficiary OPPS cost sharing by 13.2 percent (Table 6-7). However, some hospital categories would have been affected more than others:

- Overall Medicare revenue for rural hospitals would have declined by 6.9 percent compared with a 3.8 percent decline for urban hospitals.
- Nonprofit and government-owned hospitals would have had larger decreases in overall Medicare revenue than for-profit hospitals.
- Major teaching hospitals and nonteaching hospitals would have had larger decreases in overall Medicare revenue than other teaching hospitals.
- Hospitals that had disproportionate share hospital (DSH) patient percentages of less than the median (28.1 percent) would have had larger declines in overall Medicare revenue compared with hospitals that had DSH patient percentages above the median.
- Hospitals that had 100 or fewer beds would have had larger decreases in overall Medicare revenue than hospitals that had more beds.

Limiting the effects of aligning payment rates on hospitals that serve low-income patients

This impact assessment ignores an element of the current OPPS: Sections 1833(t)(9)(A) and 1833(t)(9)(B) of the Social Security Act (SSA) require that when CMS adjusts the relative weights in the OPPS, the agency must make budget-neutral adjustments to fully offset the effects on Medicare expenditures resulting from the adjustment to the relative weights. The payment alignment policy we have presented would affect the relative weights in the OPPS. Therefore, Sections 1833(t)(9)(A) and 1833(t)(9)(B) of the SSA would require CMS to use a budget-neutrality adjustment to offset the reduced Medicare spending under the OPPS that would occur from aligning payment rates across ambulatory settings. CMS would apply a uniform percentage increase to the OPPS payment rates of the 101 APCs not included in the payment alignment policy.

The primary effect of the budget-neutrality adjustment is that it would fully offset the aggregate decrease in Medicare spending and beneficiary cost sharing that would result from the payment alignment policy. That is, the net change in aggregate Medicare spending and beneficiary cost sharing would be zero, with no savings for the program or for beneficiaries unless provider behavior changed.

However, the budget-neutrality policy would not explicitly target any specific group of hospitals. Some hospitals that are the primary source of access to physician services for low-income patients would experience reductions in Medicare revenue under the payment alignment policy, which could adversely affect access for these beneficiaries. In response to these concerns, policymakers could consider an alternative to the budget-neutrality policy that would generate savings for the Medicare program and its beneficiaries while limiting reductions in revenue for hospitals that serve a high share of low-income beneficiaries.

Over time, the payment rate alignment policy would produce savings for the Medicare program and lower cost sharing for beneficiaries under either the budget-neutrality or the stop-loss policy because incentives to shift services from the lower-cost physician office and ASC settings to the higher-cost HOPD setting would be

TABLE 6–7

Change in overall Medicare revenue from aligning OPPS payment rates with PFS and ASC rates for select ambulatory services, assuming no budget-neutrality adjustment, 2019

	Percent change	
Category	**Overall Medicare revenue**	**Outpatient cost sharing**
All hospitals	–4.1%	–13.2%
Urban	–3.8	–12.7
Rural	–6.9	–16.9
Nonprofit	–4.1	–13.0
For profit	–3.3	–12.5
Government	–4.6	–14.8
Major teaching	–4.0	–14.2
Other teaching	–3.7	–12.3
Nonteaching	–4.5	–13.3
DSH patient percentage		
Below median	–4.3	–13.3
Above median	–3.8	–13.1
Number of beds		
Less than 50	–8.1	–18.6
50–100	–6.6	–16.5
101–250	–4.4	–13.5
251–500	–3.5	–12.0
More than 500	–3.5	–12.5

Note: OPPS (outpatient prospective payment system), PFS (physician fee schedule), ASC (ambulatory surgical center), DSH (disproportionate share hospital). "Overall Medicare revenue" is the sum of Medicare revenue across multiple hospital service lines, including inpatient, outpatient, swing bed, skilled nursing facility, rehabilitation, psychiatric, and home health services. "DSH patient percentage" is the sum of the percentage of inpatient days for Medicare beneficiaries that are attributed to patients who are eligible for both Medicare Part A and Supplemental Security Income and the percentage of inpatient days for all patients that are attributable to patients eligible for Medicaid but not eligible for Medicare Part A. Inpatient days are the number of days of inpatient care. This table reflects the effects of aligning OPPS payment rates with PFS payment rates for 57 ambulatory payment classifications (APCs) combined with the effects of aligning OPPS payment rates with ASC payment rates for 11 APCs, assuming no budget-neutrality adjustment within the OPPS.

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

mitigated. Reducing the shift of services from physician offices and ASCs to HOPDs would produce savings for Medicare and lower cost sharing for beneficiaries in the future.

It is not clear what effect the payment alignment policy would have on hospitals' overall Medicare margin. The impact on the margin would be affected by what is done with the savings from the aligned payment rates and how hospitals respond to the change in policy. If the payment alignment policy were coupled with a budget-neutral adjustment to the OPPS payment rates of the nonaligned APCs, there would be no effect on the overall Medicare margin. In contrast, if the savings from the payment alignment policy were used strictly

TABLE 6–8

Change in overall Medicare revenue from aligning OPPS payment rates with PFS and ASC rates for select ambulatory services, coupled with budget-neutrality policy

Category	Percent change in overall Medicare revenue from payment alignment policies combined with budget-neutral adjustment
All hospitals	0.0%
Urban	0.2
Rural	–2.3
Nonprofit	0.0
For profit	1.0
Government	–0.9
Major teaching	–0.9
Other teaching	0.5
Nonteaching	0.2
DSH patient percentage	
Below median	0.2
Above median	–0.2
Number of beds	
Less than 50	–2.9
50–100	–1.7
101–250	0.0
251–500	0.6
More than 500	0.0

Note: OPPS (outpatient prospective payment system), PFS (physician fee schedule), ASC (ambulatory surgical center), DSH (disproportionate share hospital). "Overall Medicare revenue" is the sum of Medicare revenue across multiple hospital service lines, including inpatient, outpatient, swing bed, skilled nursing facility, rehabilitation, psychiatric, and home health services. "DSH patient percentage" is the sum of the percentage of inpatient days for Medicare beneficiaries that are attributed to patients who are eligible for both Medicare Part A and Supplemental Security Income and the percentage of inpatient days for all patients that are attributable to patients eligible for Medicaid but not eligible for Medicare Part A. Inpatient days are the number of days of inpatient care. Under current law, CMS would be required to use a budget-neutrality adjustment to offset the reduced Medicare spending under the OPPS that would occur from aligning payment rates across ambulatory settings. This table reflects the effects of aligning OPPS payment rates with PFS payment rates for 57 ambulatory payment classifications (APCs) combined with the effects of aligning OPPS payment rates with ASC payment rates for 11 APCs on hospitals' overall Medicare revenue, assuming a budget-neutrality adjustment within the OPPS. Positive values indicate that the hospital category would have higher overall Medicare revenue under a policy that combines payment alignment with the budget-neutral adjustment relative to standard OPPS payment policies.

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

to reduce Medicare spending and beneficiary cost sharing, the effect on the overall Medicare margin would be large. In addition, if hospitals responded to the payment alignment policy by reducing their provision of the services for which payments were aligned across settings, the effect on the overall Medicare margin would be mitigated.

Effects of a budget-neutral adjustment of nonaligned APCs

To assess the impact of aligning payment rates under the current budget-neutrality requirements, we increased the OPPS payment rates by a uniform percentage for the 101 service APCs for which payment rates should not be aligned across ambulatory care

settings. We increased the OPPS payment rates for these APCs by 24.4 percent, which would fully offset the decrease in hospitals' overall Medicare revenue under the payment rate alignment.

Because the provision of services differs across hospitals (with some providing comparatively more of certain types of services), the financial effect of reducing payments for the 68 APCs would differ across hospitals, even with a budget-neutrality adjustment. Overall Medicare revenue would fall by 2.3 percent for rural hospitals and rise by 0.2 percent for urban hospitals (Table 6-8). In addition, for-profit hospitals would see a net gain in overall Medicare revenue of 1.0 percent, whereas nonprofit hospitals would have no change in overall revenue and government-owned hospitals would have a decrease of 0.9 percent (Table 6-8).

Relative to the change in overall Medicare revenue under the payment rate alignment without the budget-neutrality adjustment (see Table 6-7, p. 181), the hospital categories that would benefit most from the budget-neutrality adjustment—measured by the difference between the percentage change in overall Medicare revenue with the budget-neutral adjustment versus without the adjustment—included rural hospitals, hospitals with DSH patient percentages below the median, hospitals with 100 or fewer beds, and nonteaching hospitals. Government hospitals and hospitals with DSH patient percentages above the median would benefit less than the average hospital, which is a concern because these hospitals often serve a high share of low-income beneficiaries. Some hospital categories, however, would have higher overall Medicare revenue with the payment alignment policies coupled with the budget-neutrality adjustment than they would under standard OPPS payment rates. These hospital categories have positive values for the percentage change in Table 6-8.

Design of illustrative stop-loss policy

Combining alignment of payment rates with a budget-neutrality adjustment within the OPPS would lower incentives for hospitals to consolidate with physician practices but would reduce savings for Medicare and beneficiaries. However, if the budget-neutrality adjustment were not applied, some hospitals that are the primary source of access to physician services for low-income patients would experience reductions in Medicare revenue under the payment alignment policy, which could adversely affect access for these beneficiaries. In response to these concerns, policymakers could consider an alternative to the budget-neutrality policy that would explicitly target hospitals that serve a high share of low-income beneficiaries to limit the loss of Medicare revenue for these hospitals.

In considering an alternative to an across-the-board budget-neutrality adjustment, we evaluated a stop-loss policy that would be a temporary, narrowly focused approach to ensure access to care among low-income beneficiaries who rely on safety-net hospitals. Such a policy would require congressional action because current law requires CMS to make payment policy changes budget neutral. (If policymakers consider a stop-loss policy, they should also consider that some of these hospitals receive additional payments as rural emergency hospitals, which is a type of rural hospital that the Congress created in 2020.)

In previous analyses, the Commission addressed access to care for low-income beneficiaries by evaluating the effects of combining a phase-in of aligned payment rates over a three-year period with a stop-loss policy that would limit the payment reductions to 2 percent of overall Medicare revenue during the phase-in for hospitals that have DSH patient percentages above the median (Medicare Payment Advisory Commission 2013, Medicare Payment Advisory Commission 2012). The Commission found that this policy would have a modest effect on mitigating the declines in hospitals' overall Medicare revenue and would affect only 7 percent of hospitals. However, applying a stop loss to the payment alignment policy analyzed in this chapter should have a larger loss limit than 2 percent because the effects of this policy are larger than those evaluated in our previous studies.

Historically, the Commission has used DSH patient percentages to determine the extent to which hospitals serve low-income or vulnerable populations. However, the Commission is currently evaluating alternative measures to the DSH patient percentage to identify these hospitals more accurately. Because the Commission has not made a final determination of the best measure for identifying hospitals that serve a high

TABLE 6–9

Change in overall Medicare revenue for hospitals under a payment alignment policy across ambulatory care settings with and without a stop-loss provision

	Percent change, overall Medicare revenue under payment alignment policies	
Category	**Without stop loss**	**With stop loss**
All hospitals	–4.1%	–3.6%
Urban	–3.8	–3.4
Rural	–6.9	–5.5
Nonprofit	–4.1	–3.7
For profit	–3.3	–3.1
Government	–4.6	–3.8
Major teaching	–4.0	–3.5
Other teaching	–3.7	–3.3
Nonteaching	–4.5	–4.0
DSH patient percentage		
Below median	–4.3	–4.3
Above median	–3.8	–3.0
Number of beds		
Less than 50	–8.1	–7.3
50–100	–6.6	–5.5
101–250	–4.4	–3.8
251–500	–3.5	–3.1
More than 500	–3.5	–3.1

Note: DSH (disproportionate share hospital). "Overall Medicare revenue" is the sum of Medicare revenue across multiple hospital service lines, including inpatient, outpatient, swing bed, skilled nursing facility, rehabilitation, psychiatric, and home health services. "DSH patient percentage" is the sum of the percentage of inpatient days for Medicare beneficiaries that are attributed to patients who are eligible for both Medicare Part A and Supplemental Security Income and the percentage of inpatient days for all patients that are attributable to patients eligible for Medicaid but not eligible for Medicare Part A. Inpatient days are the number of days of inpatient care. This table reflects the effects of aligning OPPS payment rates with physician fee schedule payment rates for 57 ambulatory payment classifications (APCs) combined with the effects of aligning OPPS payment rates with ambulatory surgical center payment rates for 11 APCs, assuming no budget-neutrality adjustment within the OPPS, with and without a stop-loss provision for hospitals that (1) have a DSH patient percentage greater than 28.1 percent and (2) otherwise would have a decrease in overall Medicare revenue of greater than 4.1 percent due to the payment rate alignment policy.

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

share of low-income beneficiaries, we chose to use the DSH patient percentage in this illustrative example of a stop-loss policy.

For illustrative purposes, we evaluated the effects of a stop-loss limit for hospitals with a DSH patient percentage above the median of 28.1 percent that would have a decrease in overall Medicare revenue of greater than 4.1 percent from the payment rate alignment policy. No other hospitals would receive stop-loss benefits. We chose a stop-loss limit of 4.1 percent because that is the median percentage loss in overall Medicare revenue among OPPS hospitals.

Under this stop-loss policy, about 23 percent of hospitals would have reductions in overall Medicare revenue capped at 4.1 percent, and the other 77 percent of hospitals would receive no benefits from the stop-loss policy. Under this stop-loss policy, the decrease in overall Medicare revenue for all hospitals would be 3.6 percent (versus 4.1 percent without the loss limit) (Table 6-9). The types of hospitals that would benefit the most from the stop-loss policy include rural hospitals, government-owned hospitals, and hospitals that have 100 beds or fewer. Rural hospitals would benefit the most among all hospital categories; the percentage decrease in overall Medicare revenue for rural hospitals would fall from 6.9 percent without the stop-loss policy to 5.5 percent with the stop-loss policy. ■

Endnotes

1 When a hospital purchases a physician practice or ASC and converts it to an HOPD to obtain higher payment rates, the hospital may need to make changes to the office or ASC to comply with regulatory requirements applicable to HOPDs.

2 The OPPS also has 512 APCs for drugs and devices. The number of service APCs is fairly stable from year to year, but the number of drug and device APCs varies as new drugs and devices are brought to market and as all older devices and some older drugs become packaged into the payment rates of the related services.

3 For diagnostic tests, the PFS payment rates are the sum of a professional component and technical component. The technical component is equivalent to the difference between the nonfacility and facility PEs.

4 The hospital cost data are charges adjusted to costs using hospital cost-to-charge ratios from hospital cost reports. CMS uses these cost data to create the OPPS payment rates.

5 The weights are the volume in the three ambulatory settings for the HCPCS codes in APC 5151.

6 Beneficiaries who have full dual-eligibility status have both Medicare benefits and full Medicaid benefits. In contrast, beneficiaries who have partial dual-eligibility status have Medicare benefits and only partial Medicaid benefits, such as having their Medicare cost sharing or Medicare premiums covered by Medicaid.

7 The change in beneficiary cost sharing could be smaller than our estimates because some state Medicaid programs do not pay Medicare cost sharing if the difference between the Medicare payment rate for the service and the cost sharing for the service is greater than the Medicaid payment rate. In these situations, the effect of the payment alignment policies on beneficiaries' cost-sharing liabilities would be zero, and the aggregate effect of the payment alignment policies would be smaller than the amounts we report in this chapter.

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