

# Aligning fee-for-service payment rates across ambulatory settings

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# Background on Commission's payment alignment work

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- 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

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- 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

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- 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

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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

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Note: HOPD (hospital outpatient department).

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

# Issues to address when aligning payment rates across ambulatory settings

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- 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

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- 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

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- 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

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- 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

# Aligning payment rates across three ambulatory settings for 68 APCs

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- 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)

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

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- 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

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

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

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- 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

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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.

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

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- 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

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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.



# Rationale for aligning payment rates across ambulatory settings

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- 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

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- 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

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- 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