CHAPTER 6

Changing Medicare's Payment Systems for Ambulatory Care Facilities

RECOMMENDATIONS

In establishing ambulatory care prospective payment systems in general, the Secretary should:

6A Define the unit of payment for ambulatory care facilities as the individual service, consisting of the primary service that is the reason for the encounter, the ancillary services and supplies integral to it, and limited follow-up care, but not the physicians' services. The unit of payment should be defined consistently across all ambulatory care settings.

6B Use costs of individual services, not groups of services, to calculate the relative weights that apply to ambulatory care prospective payment systems. Relative weights should be calculated consistently across all ambulatory settings.

6C Evaluate payment amounts under both the hospital outpatient prospective payment system and the ambulatory surgical center prospective payment system together with practice expense payments for services provided in physicians' offices under the revised Medicare Fee Schedule to ensure that unwarranted financial incentives that could inappropriately affect decisions regarding where case is provided are not created.

6D Study means of adjusting base prospective payment rates for patient characteristics such as age, frailty, comorbidities and coexisting conditions, and other measurable traits.

6E Seek legislation to develop and implement a single update mechanism that would link conversion factor updates to volume growth across all ambulatory care services.

In implementing a prospective payment system for the hospital outpatient setting, the Secretary should:

6F Not use patient diagnosis to calculate relative weights or make payments, but rather should base payment for these services on the medical visit indicator coded using the Health Care Financing Administration Common Procedure Coding System.

6G Closely monitor hospital outpatient service use to ensure that beneficiary access to appropriate care is not compromised.

6H Re-evaluate the decision not to make additional payment adjustments under the new system, and should tie any proposed adjustments to patient characteristics. Any such facility-level adjustments that are proposed until such time as a patient level adjuster is available should reflect the population of Medicare patients treated by facilities identified to receive such adjustments.

6I Seek, and the Congress should pass, legislation to increase the rate of the beneficiary coinsurance buy-down. The cost of the faster buy-down should be financed by increases in program spending, rather than through additional reductions in payments to hospitals.

In changing the prospective payment system for ambulatory surgical centers, the Secretary should:

6J Carefully monitor changes in service provision between the ambulatory surgical center and physician office setting that may occur after HCFA's loosening of numerical guidelines for determining ambulatory surgical center list eligibility.

CHAPTER 6

Changing Medicare's Payment Systems for Ambulatory Care Facilities

In this chapter

- Balanced Budget Act reforms: implementing ambulatory care prospective payment
- General recommendations for all ambulatory care settings
- Recommendations specific to the prospective payment system for hospital outpatient services
- Recommendation specific to the prospective payment system for ambulatory surgical centers

Medicare spending for ambulatory care services—medical evaluation and management visits, minor surgical procedures, diagnostic imaging, and laboratory tests — has grown substantially since the early 1980s. Medicare pays for many of these services differently according to where they are provided. Until the enactment of the Balanced Budget Act of 1997, Medicare used cost- and charge-based reimbursement in the hospital outpatient setting to pay for these services. In this chapter, the Medicare Payment Advisory Commission offers recommendations on making payments more equitable across settings and services, by using a common definition of the unit of payment, using a common method to calculate relative weights, and moving all payments for ambulatory care—including physicians' fees—under a combined volume control and update mechanism. We also make several specific technical recommendations regarding implementation of the hospital outpatient prospective payment system mandated by the Balanced Budget Act of 1997, and recommend reducing the inappropriately high beneficiary coinsurance for hospital outpatient services.

Ambulatory care comprises a wide variety of medical services, provided in an equally wide variety of settings. In general, the term covers those acute care services that do not require an inpatient hospital stay or other facility admission and are provided in a relatively tightly defined clinical "encounter."

As ambulatory care has grown over time to represent an ever larger share of total Medicare payments, problems with the existing payment systems have been highlighted. The Congress addressed many of these problems in specific provisions of the Balanced Budget Act of 1997 (BBA). But because of the scope and number of BBA-mandated changes to ambulatory care payment policies, there is considerable uncertainty regarding the ways in which providers and beneficiaries will be affected once the changes are fully implemented.

This chapter focuses primarily on Medicare's policies governing facility payments.[1] After describing the major

Prior law payment systems for ambulatory care

Medicare's payment method for hospital outpatient services under pre-BBA mechanisms is one of the most complicated components of the program. Over time, it has evolved into an intricate patchwork of different mechanisms, each aimed at specific services or specific classes of hospitals. Further, the services provided in hospital outpatient departments can also be provided in other facilities such as ambulatory surgical centers (ASCs).

Hospital outpatient departments

Payments to hospital outpatient departments, which account for the bulk of Medicare's spending for ambulatory facility services, have risen at an annual rate of over 12 percent since 1983 reaching $17.2 billion in 1997 (see Table 6-1). Medicare spending for hospital outpatient services has also grown as a percentage of total Medicare payments to hospitals, growing from about 7 percent in 1983 to nearly 20 percent in 1997. At present, most short-term hospitals provide outpatient services to Medicare beneficiaries.

Under prior law, Medicare reimbursed hospitals for most outpatient services using three different payment methods: the lesser of costs or charges; the lesser of costs, charges, or a blended rate; and a number of fee schedules (for clinical laboratory services, prosthetics and orthotics, and durable medical equipment) with the specific method based on type of service. Except for the fee schedules, these payment methods were applied retrospectively on an aggregate basis during the settlement of the hospitals' Medicare cost reports. As a result it was difficult, if not impossible, to know the amount Medicare paid for a given outpatient service; even if this amount could have been determined, it could only have been known once the cost reporting process was complete, long after the service was provided.

Lesser of costs or charges

Medicare payments for medical visits (evaluation and management services), therapy and rehabilitation services, and some surgeries furnished in hospital outpatient settings were based on the facility's reasonable costs or customary charges.[2] This payment method offered no incentive for hospitals to control their costs because increases in hospitals' costs generally resulted in increased payments. Conversely, hospitals that reduced their costs generally received reduced payments.

The beneficiary coinsurance for these services was 20 percent of hospitals' charges. Because charges for hospital outpatient services (particularly services subject to a blended rate) have grown faster than hospitals' costs (and therefore faster than Medicare payments), the coinsurance payment grew over time to represent a larger and larger share of total payments to hospitals. Currently, beneficiary coinsurance represents about 47 percent of the total Medicare payment hospitals receive for outpatient services, compared with 20 percent for most other services.

Lesser of costs, charges, or a blended rate

In an effort to contain program spending, the Congress restructured Medicare payment methods in the late 1980s. Hospitals providing ASC-approved surgical procedures and certain radiology and diagnostic procedures were paid the lesser of their costs, charges, or a blended rate, which combined a fee schedule amount with the lesser of their costs or charges. The Medicare program achieved savings under the blended rates because hospital costs and charges generally were higher than the ASC rates or relevant fee schedule amounts. Except for technical modifications, these formulas still define how the Health Care Financing Administration (HCFA) pays for services subject to a blended payment limitation.

The blended payment methodology is flawed in two specific ways. First, an error in the formula

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1 Although ambulatory care does encompass the physicians' office setting, a broader treatment of physician payment issues is found in Chapter 7 of this report. Similarly, while many rehabilitative services are provided on an outpatient basis by certain types of ambulatory providers, these services are distinct enough from the more acute services traditionally classified as ambulatory care to warrant a separate discussion in Chapter 4.

2 Under Medicare reimbursement rules, hospitals' outpatient operating costs are reduced by 5.8 percent and their capital costs by 10 percent for purposes of calculating payments. As a result, the highest payment-to-cost ratio a hospital could theoretically attain was 0.942, in the case of facilities with no outpatient capital costs.

Prior law payment systems for ambulatory care

TABLE 6-1

Medicare spending for ambulatory services provided in selected ambulatory settings, 1983-1997 (in billions)

	Hospital outpatient departments	Ambulatory surgical centers
1983	$3.2	N/A
1984	3.7	N/A
1985	4.4	N/A
1986	5.2	$0.1
1987	6.2	0.2
1988	7.0	0.3
1989	7.6	0.3
1990	8.5	0.4
1991	9.7	0.4
1992	11.0	0.6
1993	12.3	0.6
1994	13.9	0.7
1995	15.4	0.8
1996	16.6	0.9
1997	17.2	1.1

Note: 1983-1985 spending figures unavailable at time of publication.

Source: HCFA, Office of Information Services, and MedPAC analysis of Medicare Cost Reports.

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used to calculate the blended payment meant that the program payment amount did not properly reflect the full offset of beneficiary coinsurance. As a result, hospitals paid a blended rate received an excess payment from Medicare, known as formula-driven overpayment (FDO). Second, blended rates provided hospitals with an incentive to increase their charges relative to their costs and the relevant fee schedule amounts for services subject to a blended payment calculation. If hospitals increased their charges enough, they could avoid the blended rates altogether by shifting a larger share of the payment liability to the beneficiary.

Prospective payment rates

A number of Medicare services provided in hospital outpatient facilities are paid using prospective payment rates. These include laboratory services, prosthetics and orthotics, physical therapy, mammography screening, and some surgical dressings and supplies. Hospitals provide dialysis services under a prospective composite rate as well. Medicare's payments are generally the lesser of hospital charges or Medicare's applicable fee schedule. Such fee schedule payment systems achieve savings for the Medicare program because their rates are generally below the payments that would have been made under cost-based methods.

Ambulatory surgical centers

In the fall of 1982, Medicare began covering certain surgical procedures provided in ASCs. A Medicare-certified ASC is a distinct facility that provides outpatient surgery services exclusively, has an agreement with HCFA to participate in Medicare as an ASC, and meets certain conditions of participation (42 CFR § 416.2).

Medicare began to cover ASC services largely as a means of reducing spending growth by shifting some inpatient care to less costly facilities. These services were defined as surgical procedures that were generally provided on an inpatient basis but could safely be performed in less intensive ambulatory sites. This definition was intended to encourage the migration of inpatient surgical procedures to the less costly ASC setting, without encouraging a shift of services from the office setting to ASCs, where reimbursement is generally higher. These concepts formed the basis for HCFA's list of services that would be covered in ASCs.

The ASC benefit represents one of Medicare's earliest experiments with prospective payment in ambulatory settings. Procedures that Medicare included on the ASC list in 1983 initially were assigned to one of four groups for payment purposes on the basis of their estimated costs, and a prospective payment rate was calculated for each group. Beneficiaries were liable for 20 percent of the ASC rate. Over time, the number of eligible procedures increased, as did the number of payment groups. Currently, there are some 2,500 surgical procedures on the ASC list, grouped into eight payment categories.

Since the inception of the ASC benefit, the number of ASCs participating in the Medicare program has grown rapidly. At the end of 1983, just 239 ASCs provided services to Medicare beneficiaries. By 1998, more than 2,300 such facilities were participating in the program. As the number of Medicare-certified ASCs increased over time, so did payments and service use. Medicare program payments to ASCs increased in the mid-1990s by about 12 percent annually, from nearly $500 million in 1993 to almost $700 million in 1996. ASC service volume increased by 13 percent annually over this same period, from just over one million allowed services in 1993 to slightly over 1.5 million services in 1996.

components of Medicare's ambulatory care payment systems, the chapter identifies a number of areas requiring important policy decisions and presents the Commission's recommendations on how those decisions should be made.

Balanced Budget Act reforms: implementing ambulatory care prospective payment

The Congress remedied many of the problems with Medicare's hospital outpatient payment system by specific provisions of the BBA. For example, the BBA eliminated the formula-driven overpayment with cost reporting periods beginning in fiscal year 1998. It also directed the Health Care Financing Administration (HCFA) to implement a prospective payment system (PPS) for hospital outpatient services. For the first time since the inception of the program this system will allow hospitals to know their payments for outpatient services in advance. The outpatient PPS will also sever the direct link between hospitals' costs and charges and the payments they receive, eliminating the incentive to increase reported costs in order to receive higher Medicare reimbursements. Finally, the outpatient PPS will begin to reduce the disproportionate beneficiary coinsurance liability.

These benefits to the Medicare program and its beneficiaries come at a price, however. The program savings from the BBA's provisions represent reduced payments to hospitals. Under prior law, the highest Medicare reimbursement a hospital could receive for outpatient services was about 94 percent of their reported costs. In the aggregate, payments for hospital outpatient department (OPD) services were about 90 percent of reported costs in 1996 with considerable variation among classes of hospitals (see Table 6-2). If the formula-driven overpayment had been eliminated in that year, aggregate payments to hospitals would have fallen by about 9 percent, reducing aggregate payments to about 82 percent of costs, but with different impacts by class of hospital. Further, HCFA estimates that additional reductions in payments will occur as the hospital outpatient PPS is implemented sometime in 2000, with some groups of hospitals experiencing very sharp reductions in payments (HCFA 1998a).

Indeed, the BBA intended to reduce both the level of payments to hospitals for outpatient services (by eliminating the formula-driven overpayment) and the future rate of growth in spending (through the legislated updates to the conversion factor), and to provide financial relief to the program's beneficiaries who receive ambulatory services in the hospital outpatient setting. However, the magnitude of the resulting effects indicates that HCFA should pay close attention to the design and implementation of the new payment system to ensure that these changes do not reduce beneficiary access to appropriate outpatient services.

At the same time that HCFA is implementing BBA-prescribed changes to the hospital outpatient payment system, the agency will similarly update its payment system for ambulatory surgical centers. Simultaneously, HCFA will make substantial changes in the way it calculates and pays for physicians' practice expenses under the Medicare Fee Schedule. Given both the scope and the number of changes that are occurring in Medicare's ambulatory care payment systems, the Medicare Payment Advisory Commission (MedPAC) has developed a number of recommendations that may assist HCFA in making these changes.

MedPAC's ambulatory care recommendations are in three categories. The first set of recommendations applies to ambulatory care in general, regardless of setting. The second set of recommendations deals with specific elements of HCFA's proposed PPS for hospital outpatient services. Finally, we present a recommendation dealing with HCFA's proposed changes to the ASC benefit.

General recommendations for all ambulatory care settings

These recommendations address the major steps involved in designing an ambulatory care prospective payment system:

- defining the unit of payment,
- calculating relative weights,
- evaluating payment amounts across settings,
- adjusting payments across settings, and
- controlling spending through rate updates.

Taken together, these recommendations lay the groundwork for bringing consistency to Medicare's ambulatory care payment systems.

Defining the unit of payment

Developing prospective payment systems requires defining the unit of payment or the package or bundle of services that the payment is intended to cover (see Chapter 1).

RECOMMENDATION 6A

The secretary should define the unit of payment for ambulatory care facilities as the individual service, consisting of the primary service that is the reason for the encounter, the ancillary services and supplies integral to it, and limited follow-up care, but not the physicians' services. The unit of payment should be defined consistently across all ambulatory care settings.

TABLE 6-2

Medicare hospital outpatient payment-to-cost ratios, with impacts attributable to elimination of formula-driven overpayment and prospective payment system implementation

Hospital group	1996 actual payment-to-cost ratio, before formula-driven overpayment elimination	1996 estimated payment-to-cost ratio, after formula-driven overpayment elimination	HCFA estimate of additional percentage change with PPS implementation	Implied outpatient payment-to-cost ratio under PPS, based on HCFA estimates	Percent of Medicare revenue attributble to outpatient services
All hospitals	0.8958	0.8152	− 0.038	0.7842	9.9
Rural	0.9157	0.8234	− 0.052	0.7806	14.7
Urban	0.8912	0.8133	− 0.033	0.7865	9.3
Bedsize (rural)					
< 50	0.8873	0.8073	− 0.098	0.7282	19.6
50 - 99	0.9112	0.8120	− 0.069	0.7560	15.5
100 - 149	0.9288	0.8260	− 0.046	0.7880	13.5
150 - 199	0.9290	0.8354	− 0.020	0.8187	13.0
200 +	0.9336	0.8518	0.001	0.8527	11.4
Bedsize (urban)					
< 100	0.8802	0.7982	− 0.074	0.7391	15.5
100 - 199	0.8834	0.8289	− 0.025	0.8082	10.4
200 - 299	0.9116	0.8289	− 0.007	0.8231	9.2
300 - 499	0.9126	0.8377	− 0.033	0.8101	8.6
500 +	0.8477	0.7783	− 0.070	0.7238	8.3
Teaching activity[a]					
Major teaching	0.8422	0.7745	− 0.094	0.7017	9.2
Other teaching	0.8945	0.8173	− 0.018	0.8026	9.1
No teaching	0.9123	0.8269	− 0.031	0.8013	11.2
Proprietary	0.9266	0.8484	− 0.011	0.8391	7.9
Voluntary	0.9096	0.8263	− 0.040	0.7932	9.9
Government	0.8137	0.7435	− 0.040	0.7138	12.5
Cancer hospitals	0.8727	0.8123	− 0.292	0.5751	22.0
Rural DSH[b]	0.9093	0.8181	N/A	N/A	N/A
Urban DSH	0.8823	0.8069	N/A	N/A	N/A
Non DSH	0.9145	0.8278	− 0.003	0.8253	25.1

Note: Payment-to-cost ratios are for service payments and costs only and do not include settlement adjustments. DSH (disproportionate share). HCFA (Health Care Financing Administration). PPS (prospective payment system).

[a] HCFA measures teaching activity by number of residents; MedPAC uses resident-to-bed ratio.

[b] HCFA and MedPAC use different definitions. In general, outpatient percentage of Medicare payments varies inversely with DSH, but the PPS impacts vary with DSH: higher DSH percentage results in greater impacts.

Source: MedPAC analysis of PPS-13 Medicare Cost Reports; Federal Register, September 8, 1998.

Two models for defining the payment unit in ambulatory settings can be found in Medicare's payment systems. One model is the approach that Medicare uses to reimburse hospitals for inpatient services. Medicare makes a single fixed payment for all of the services associated with a condition or procedure that is the reason for an inpatient hospital admission. The rationale for this approach is that because of the variety of services that could be provided during the course of an inpatient hospital stay and because so many of these services are related in various ways, it would be impractical to develop prospective payment rates for each possible combination. Moreover, the interval between the admission and discharge is easily defined and amenable to consideration as a single bundle of services. A single payment for a bundle of services also encourages provider innovation and efficiency in providing care, by giving hospitals an incentive to reduce the costs of providing services relative to

the fixed Medicare payment. HCFA's experience with a broadly defined payment unit in the inpatient setting has been generally successful, both in controlling the growth in program expenditures and in providing hospitals with incentives to provide more cost-efficient care to Medicare beneficiaries.

The second model for defining the unit of payment is the one used in determining payment for physicians' services. Here, the bundle or package of services that the payment amount is intended to cover is more tightly defined. It consists of the HCFA Common Procedure Coding System (HCPCS)-coded primary service that is the reason for the visit and those medical and surgical supplies "incident to" it (42 CFR § 414.34).[3] Other major services provided in conjunction with a medical visit in a physician's office are reimbursed separately under relevant payment policies.

The most appropriate model for the hospital outpatient PPS depends on the perception of outpatient services. Because the outpatient department is an integral part of the hospital, one could argue that the services it provides should be treated more like other hospital services. In contrast, hospital OPD services can be seen as relating to a more tightly circumscribed encounter and therefore more like services provided in the physicians' office.

MedPAC believes that services provided in the hospital outpatient setting are more analogous to office-based services than they are to inpatient admissions. First, the duration, scope, intensity, and range of services provided in the outpatient and office settings are sufficiently similar that they can be described by the same HCPCS coding system. Second, many of the distinctions that once separated the different types of ambulatory facilities are blurring, and often the same service can be provided in an OPD, physician's office, or other freestanding facility. The unit of payment should therefore be defined as the individually coded primary service and its necessary and essential ancillary services and supplies, including limited follow-up care, if integral to the primary service.[4] This definition reflects the short-term nature of the ambulatory encounter, and should be applied consistently across ambulatory settings.

Calculating relative weights

The next step in designing ambulatory care prospective payment systems requires calculating a set of relative weights to differentiate payments among services.

RECOMMENDATION 6B

The Secretary should use costs of individual services, not groups of services, to calculate the relative weights that apply to ambulatory care prospective payment systems. Relative weights should be calculated consistently across all ambulatory settings.

HCFA has chosen to group ambulatory services in the hospital outpatient setting—and in the ASC setting—for purposes of payment, using a system known as Ambulatory Payment Classification (APC). The APC payment system is similar to that currently used in the ASC setting in that services and procedures with similar costs are grouped together to calculate payments; each of the discrete procedures in a group is paid the same amount.[5] APCs are thought to be an improvement over the previous ASC payment groups in that the APC groups are constituted on the basis of the clinical similarity of services and patient diagnoses as well as service costs. Under HCFA's proposal, the full range of ambulatory services will be classified into approximately 300 APC payment groups.

Alternatively, relative weights—and the corresponding payment amounts—could be calculated at the level of the individual HCPCS-coded service. In this case, the resulting set of relative weights would look more like those used under the Medicare Fee Schedule for physicians' services. Each procedure or service would have its own relative weight, calculated independently from data specific to that service, relative to all other services.

HCFA has espoused a grouping approach for several reasons. First, the agency believes that grouping services facilitates pricing for new or low volume services and procedures. A relatively small number of discretely coded services accounts for the majority of Medicare outpatient use (MedPAC 1998a; MedPAC 1998b). Given this distribution of services, HCFA believes that calculating individual relative weights for low volume services would imply "a level of precision that is often not warranted due to low procedure volume or questionable cost data" (HCFA 1998a).

Second, HCFA argues that grouping may discourage "upcoding," which occurs when two closely related services or procedures have significantly different payment rates, and providers report the higher-priced code when submitting their claims to Medicare. The inpatient analog to upcoding has been empirically documented (Carter, et al. 1990; Carter, et al. 1991). Grouping services would reduce incentives for upcoding because closely related services would have the same payment rates.

HCFA lists a number of additional benefits of grouping services to calculate

3 The HCPCS consists of the American Medical Association's Current Procedural Terminology (CPT) codes and descriptions for medical procedures and services, and a variety of HCFA-specific services and procedures identified by alphanumeric codes.

4 For example, suture thread and bandages are supplies that would be considered an integral part of an initial visit to repair a laceration. Under prior law, hospitals could bill for these supplies as separate line items, without a HCPCS code identifier. Under the definition of the unit of payment recommended here, these supplies would be included in the unit of payment. Similarly, a brief follow-up visit to remove sutures could also be considered integral to the primary reason for the outpatient encounter—the laceration repair—and the facility costs incurred in providing such follow-up care could also be included in the unit of payment.

5 For example, under the current ASC payment system, upper gastrointestinal endoscopies (HCPCS code 43239) and colonoscopies with biopsy (HCPCS code 45378) have the same payment rate of $422.

relative weights, including administrative simplicity (rates need be calculated for only 300 groups rather than 5,000 individual services) and potential future consistency of payment across settings (APCs have been proposed in both the hospital outpatient and the ASC settings, and HCFA argues they could ultimately be applied in physicians' offices). Also implicit in HCFA's discussion of the proposed system is that the grouping approach can accommodate a larger unit of payment, which would act as a de facto form of volume control.

While grouping has certain potential advantages, such an approach would entail considerable costs and drawbacks. The grouping approach favored by HCFA invokes a much more complicated design logic than a service-level fee schedule. As a result, the system demands a closer analysis of its hypothesized benefits relative to its likely costs than HCFA has published in its proposed rule.

For example, HCFA notes that the grouping approach helps establish service-level relative weights and payment rates for new or low volume services, for which cost data may be unreliable, undocumented, or not readily available. However, the agency deems these same data as adequate to combine with higher-volume procedures to calculate weights for the group as a whole. In other words, the use of groups to calculate weights masks questionable cost data for low volume and new procedures. This strategy is clearly demonstrated in the proposed revisions to the ASC payment system, in which HCFA used the grouping approach to calculate weights for the 60 percent of the payment groups "for which we had little or no Medicare volume or reliable cost data" (HCFA 1998b).

HCFA also asserts that the groups are composed of procedures that are similar both in terms of clinical indications and resource costs. The first part of this claim is subject to interpretation, and there is no evidence in the proposed rule to assess the validity of the second. However, the disproportionate impacts on different classes of hospitals in changing to the new outpatient PPS relative to the overall impact suggest that the APC groups may be less homogeneous than HCFA believes.

Finally, it is likely that hospitals will experience an additional administrative burden in changing to the new system. Hospitals may be required to purchase or develop new computer software and will experience additional education and training costs stemming from the APC grouping approach. MedPAC believes that the burden imposed by the APC system outweighs its benefits in ambulatory settings.

Evaluating payment amounts across settings

Medicare's payment systems for ambulatory care are in considerable flux as this report goes to press. Some of HCFA's proposals are being implemented, some are still under development, some are being revised in light of solicited comments, and some have been proposed, but are stalled because of nonpolicy considerations, such as adjusting computer systems to deal with the year 2000 problem. However, it is clear that once these various new payment systems and revisions of existing systems are put into place, Medicare's ambulatory care landscape will be very different from that existing in the pre-BBA world.

RECOMMENDATION 6C

The Secretary should evaluate payment amounts under both the hospital outpatient prospective payment system and the ambulatory surgical center prospective payment system together with practice expense payments for services provided in physicians' offices under the revised Medicare Fee Schedule to ensure that unwarranted financial incentives that could inappropriately affect decisions regarding where care is provided are not created.

This evaluation should focus primarily on services commonly provided in more than one ambulatory setting. The Secretary should conduct such an evaluation using both a financial analysis of the payment amounts and a clinical analysis of appropriateness of setting. In the event that inappropriate payment differences are found to exist, the Secretary should begin to develop a means of recalibrating the payment amounts to minimize their potential impacts on choice of setting.

Currently, Medicare's various ambulatory care payment systems reimburse individual providers and classes of providers differently for the same service (see Table 6-3). For example, in 1996, the median payment to hospitals for a diagnostic colonoscopy was $358. The base ASC rate for the service was $408, and the base practice expense component under the Medicare Fee Schedule was $143 when the service was provided in the office setting. While some of this variation may reflect differences in the underlying cost structures among different kinds of facilities, payments could further vary within settings; in the hospital setting, the Medicare payment was more a function of each hospital's own costs and charges than any explicit payment policy.

Significant differences in payments for the same service among ambulatory settings may provide incentives that could inappropriately influence where an ambulatory service was provided. For example, the difference between the ASC rate and the practice expense payments for the diagnostic colonoscopy noted above could affect a physician's decision regarding where to perform the procedure, especially if ownership or other financial arrangements are active considerations. Previous coverage regulations governing such shifts in setting would be loosened somewhat under HCFA's new proposals. Different

TABLE 6-3

Differences in prior law and post-BBA prospective payment rates across settings for selected high-volume ambulatory care services

			Prior law (1996)			Post-BBA (1999)		
Type of service	HCPCS code	Description	Median OPD payment	ASC base rate	Practice expense base rate	OPD base rate	ASC base rate	Practice expense base rate[a]
ASC Surgery	43239	Upper GI endoscopy with biopsy	$375.00	$408.00	$119.00	$326.31	$327.00	$249.77
	45378	Diagnostic colonoscopy	358.00	408.00	143.00	347.00	405.00	303.35
	45380	Colonoscopy with biopsy	394.00	408.00	166.00	347.00	405.00	356.93
	45385	Colonoscopy with lesion removal	410.00	408.00	230.00	416.00	354.00	391.68
	66984	Extract cataract, insert lens	1150.00	903.00	517.00	977.00	863.00	---
Radiology	71010	Chest X-ray, one view	30.00	---	16.00	39.52	---	13.03
	71020	Chest X-ray, two views	30.00	---	20.00	39.52	---	17.38
	73510	X-ray of hip	32.00	---	19.00	39.52	---	15.93
	70450	CT scan of brain/head	188.00	---	156.00	256.39	---	131.76
	76091	Mammography, both breasts	39.00	---	43.00	34.96	---	36.19
Diagnostic	93000/05/10	12 lead electrocardiogram	14.00	---	15.00	17.73	---	6.90
	93015	Cardiovascular stress test	52.00	---	55.00	73.98	---	55.02
	93307	Echo exam of heart	93.00	---	127.00	143.39	---	52.49
	93880	Duplex scan of extracranial arteries	108.00	---	123.00	120.09	---	88.69
	94760	Blood oxygen level (oxymetry)	11.00	---	9.00	39.52	---	7.60
Cost-based	99201	Office or outpatient visit, new patient	85.00	---	13.00	36.48 to 77.02	---	47.78
	99213	Office or outpatient visit, established patient	54.00	---	114.00	42.06 to 66.38	---	45.25
	99281	Emergency visit, brief	70.00	---	10.00	53.71 to 102.35	---	---
	99282	Emergency visit, limited	81.00	---	14.00	53.71 to 102.35	---	---
	99283	Emergency visit, moderate	118.00	---	17.00	53.71 to 155.56	---	---

Note: BBA (Balanced Budget Act of 1997). HCPCS (HCFA Common Procedure Coding System). ASC (ambulatory surgical center). GI (gastrointestinal). OPD (outpatient department).

[a] Practice expense amounts are for first year of phase-in.

Source: MedPAC analysis of HCFA 5 percent sample physician/supplier and hospital outpatient claims, 1996; Federal Register, June 12, 1998; Federal Register, September 8, 1998.

payment rates among settings could also affect the coinsurance amounts paid by beneficiaries requiring these services.

The BBA began to phase-in substantial revisions to the practice expense component of the Medicare Fee Schedule and completely overhauled the payment system for hospital outpatient departments. At the same time, HCFA proposed to revise its payment system for ASCs. As a result, payment amounts for all ambulatory services will change once the BBA's provisions are fully implemented. However, as Table 6-3 shows, the amount paid for a given service will continue to be different depending on the setting in which it is provided. Historically, HCFA has calculated payment amounts for each setting independently, therefore the Commission cannot be certain that differences in payments under the new systems will be any more justified than they were under prior law.

Therefore, we recommend that HCFA investigate differences in payments for the same service across settings, particularly the high volume services that constitute the bulk of Medicare's ambulatory care expenditures. Specifically, pending the development of a unified payment policy for ambulatory care, HCFA should work to ensure that differences in same-service payment amounts across settings do not provide financial incentives that could unduly affect providers' decisions regarding where ambulatory care takes place. MedPAC recognizes that the rate-setting process under the Medicare Fee Schedule and the process proposed for the hospital outpatient PPS are both subject to strict legislative constraints. Changes in legislation would be required to adjust payments among settings accordingly. However, identifying the potential magnitude of this problem if such adjustments are not made is an appropriate first step.

Adjusting payments across settings

Historically, HCFA has adjusted Medicare's payments for medical

services in various settings to achieve certain policy goals, such as ensuring access to care. For example, prospective payments for inpatient services are adjusted to compensate hospitals for their teaching activity or the share of low income patients that they treat. Fee schedules are specific to geographic areas to reflect differences in input prices, and physicians are given a payment adjustment if they practice in medically underserved areas. ASC payments are adjusted by the local wage index to recognize differences in labor costs. Special payment policies have been developed to handle entire classes of hospitals and specialized facilities such as sole community hospitals, rural health clinics, and PPS-exempt hospitals. The vast majority of these adjustment mechanisms are setting specific.

RECOMMENDATION 6D

The Secretary should study means of adjusting base PPS rates for patient characteristics such as age, frailty, comorbidities and coexisting conditions, and other measurable traits.

Such adjustments would help to rationalize payments across ambulatory settings, ensure that payments more closely reflected resources used in providing care, and assist in reducing differences in payments for the same service when provided in different settings.

MedPAC believes that HCFA should use the opportunities afforded by the BBA-mandated ambulatory care payment changes to begin developing a more unified and rational ambulatory care payment system. Under such an approach, payment would be less dependent on the type of facility (or the class of facility within a given type), and more dependent on the relative costliness of providing specific services to individual patients. This principle would apply both within and among ambulatory settings.

Currently, no viable patient-level adjuster exists that could be used to calibrate payments to patient characteristics or conditions. Diagnoses at the time ambulatory services are provided are likely not appropriate for this purpose, and links between more immutable patient characteristics and ambulatory service costs have not been adequately studied. However, MedPAC believes that the benefits of this approach are substantial enough to warrant further investigation.

As an interim measure, HCFA should evaluate the appropriateness of facility-level adjustments in order to preserve access to care for particularly vulnerable segments of the Medicare population, but only if it can be demonstrated that certain classes of facilities serve relatively homogeneous populations requiring specialized care. MedPAC raises this possibility with some reservation, however, because such adjustments are often difficult to abolish once they are implemented.

Controlling spending through rate updates

Much of the increase in Medicare spending for hospital outpatient services, and ambulatory care in general, is attributable to increases in the volume of services provided. Volume growth has occurred partly due to historical growth in the Medicare fee-for-service population, but also because of increases in the number of outpatient encounters per beneficiary, and in the number of services provided in each outpatient encounter. Almost 60 percent of outpatient volume growth can be traced to such increases in service intensity (Miller and Sulvetta 1994).

Because volume growth is such a strong driving factor in increasing program expenditures for hospital outpatient services, the BBA directed HCFA to implement a volume control mechanism in conjunction with the hospital outpatient PPS.

RECOMMENDATION 6E

The Secretary should seek legislation to develop and implement a single update mechanism that would link conversion factor updates to volume growth across all ambulatory care services.

This system should apply to spending for hospital outpatient departments, ambulatory surgical centers, physicians' services, federally qualified health centers, rural health clinics, and other facilities as appropriate. The ambulatory update mechanism should not unduly restrict the appropriate migration of services from inpatient to ambulatory settings, or among ambulatory settings.

This recommendation is guided by the general premise that a potential for substitution of services exists among ambulatory care settings, and that providers may respond to perceived inadequacies in payment rates or payment rate updates by shifting services among settings. This potential is made more likely by the ongoing integration of health care providers under coordinating networks and centralized financial control. The incentive to shift services among ambulatory care settings would be minimized under a more unified ambulatory care payment system. It logically follows that a unified system would also incorporate a standardized update mechanism, and a standardized method of controlling spending growth, as necessary. A unified sustainable growth rate would help fulfill both of these requirements.

The primary means of controlling spending under a combined volume control system is the update to the conversion factors in each of the ambulatory systems. Under a unified system, aggregate volume estimates, and their corresponding Medicare spending, should be pooled across ambulatory settings. Acceptable levels of increase would be determined by quantifying factors that could contribute to increases in service use or costs across all ambulatory settings. Changes in fee-for-service enrollment, in medical technology permitting desirable shifts in setting, or in

the costs of medical services could be considered within the update framework. External factors such as growth in national income or general inflation could be considered within this framework, but would not be its primary driver. The combined system should be flexible enough to permit the continued migration of services from more costly inpatient settings to less costly ambulatory venues as medical technology continues to evolve.

Recommendations specific to the prospective payment system for hospital outpatient services

The recommendations discussed above reflect MedPAC's long-term objective of a unified prospective payment system for all ambulatory care settings. More immediately, HCFA has published a proposal for prospective payment in the hospital outpatient setting, in compliance with specific mandates in the BBA. MedPAC has a number of recommendations on the specifics of this proposal.

Using ICD-9 diagnosis codes in setting rates and making payments

The Ambulatory Payment Classification system uses two distinct methods to group and pay for ambulatory care services. Surgical procedures, radiology services, and diagnostic and imaging services are classified based on the HCPCS code corresponding to the service. Medical visits, however, are classified and paid based not only on the HCPCS-coded visit but also on the patient's diagnosis that is reported on the claim. The HCPCS-coded visit is grouped to an APC group, and the International Classification of Diseases (ICD-9-CM) diagnosis code is cross referenced to one of 20 major diagnostic categories (MDCs). HCFA chose this approach to achieve an appropriate range of payments within the medical visit category. Implicit in this approach is the notion that the range of payments becomes more pronounced when a greater scope of ancillary services is included in the unit of payment.

RECOMMENDATION 6F

The Secretary should not use patient diagnosis to calculate relative weights or make payments under the hospital outpatient PPS, at least initially. Payment for these services should be on the basis of the medical visit indicator coded using the HCPCS.

If the Secretary determines that using diagnosis codes is needed to differentiate payment, the Department should issue explicit coding instructions to providers to improve the quality of the data available to make such assessments.

Difficulties in coding have been documented since HCFA began requiring HCPCS coding for hospital outpatient reimbursement. Mismatches between hospital and physician coding for the same service have been particularly problematic. One study by the Office of the Inspector General suggested a mismatch rate of 24 percent for selected surgical procedures, which presumably would be less subject to interpretation than establishing diagnosis (OIG 1994). Such discrepancies in coding have even been documented among physician and hospital inpatient claims for the same service (OIG 1989).[6] Introducing diagnosis coding as an axis of payment raises further potential for coding discrepancies, a fact that HCFA has acknowledged previously in no uncertain terms:

> Principal diagnoses on bills submitted by Medicare physicians and suppliers in 1994 associate medical conditions identified by providers with program expenditures and services volumes. The HCFA-1500 billing form requires up to four diagnoses, in priority order. It is well-known that diagnosis coding practices may vary over time and geographically. Moreover, it is sometimes difficult for the clinician to isolate the most important diagnosis for designation as principal on a claim.
>
> (HCFA 1996)

MedPAC recognizes that stratifying payment based on the acute diagnosis attempts to achieve payments that more closely track the costs of providing services to individual beneficiaries. However, we believe that using patient diagnosis to determine payment as proposed by HCFA is not practicable, given the current state of the available data and the lack of definitive rules for reporting patients' diagnoses under the proposed system.

Monitoring hospital outpatient service use

Once the BBA's hospital outpatient provisions are fully implemented, including the elimination of the formula-driven overpayment, the beneficiary coinsurance buy-down, and the outpatient PPS, most hospitals' Medicare payments probably will go down. At the same time, HCFA is making substantial changes to the payment systems for ASCs and for physician practice expense under the Medicare Fee Schedule. However, HCFA's estimates of the anticipated impacts of these changes suggest that those experienced by hospitals, both in the aggregate and among classes of hospitals, will be the most pronounced.

RECOMMENDATION 6G

Given the magnitude of the impacts of the BBA's combined outpatient provisions, the Secretary should closely monitor hospital outpatient service use to ensure that beneficiary access to appropriate care is not compromised.

6 Interestingly, the OIG recommended in the latter case that HCFA work with the AMA to reduce the number of visit codes to help prevent nonmatching claims.

The BBA's goals included reducing the current level of payments to hospitals for outpatient services and reducing the future rate of growth of these payments. The Commission supports these measures as both desirable and necessary. However, both the magnitude of the payment reductions relative to current law and certain design elements of HCFA's proposed system could cause significant disruptions in hospitals' willingness or ability to provide Medicare beneficiaries with necessary ambulatory care services. As a result, beneficiaries may experience reduced access to these services or may find that they are only available in less desirable clinical settings.

It is likely that the differential impacts on different classes of hospitals will be reduced if HCFA adopts a payment system based on individual services, rather than groups of services. Even so, MedPAC recommends that HCFA closely monitor the provision of ambulatory care services by hospital outpatient departments once the BBA's outpatient provisions are fully implemented. In particular, HCFA should work to ensure that beneficiary access to necessary and appropriate ambulatory care is not compromised under the outpatient PPS. HCFA should monitor:

- the absolute provision of certain benchmark services in hospital OPDs,
- changes in the provision of services by certain classes of hospitals,
- shifts of OPD services to other ambulatory settings,
- changes in the rate of migration of services from inpatient to outpatient settings, and
- other measures that could indicate compromised access.

Payment adjustments within the hospital outpatient setting

Differences in payments across settings should, to the extent possible, be linked with patient characteristics that affect the relative costliness of providing the service. MedPAC believes that the same principle should equally hold true in assessing the need for payment adjustments within settings. In its proposed rule on the outpatient PPS, however, HCFA proposes only a payment adjustment to reflect differences in input prices attributable to local area wages.

RECOMMENDATION 6H

The Secretary should re-evaluate the decision not to make additional payment adjustments under the new system and should tie any proposed adjustments to patient characteristics. Any such facility-level adjustments that are proposed until such time as a patient level adjuster is available should reflect the population of Medicare patients treated by facilities identified to receive such adjustments.

In the hospital inpatient setting, Medicare adjusts its diagnosis related group (DRG) payments to recognize certain inherent cost differences and to achieve certain policy goals. For example, hospitals that treat a large share of low income patients and those that engage in high levels of teaching activity receive adjustments to their payments that reflect Medicare's valuation of these activities. Similarly, providers such as sole community hospitals and rural referral centers are subject to separate payment policies due to their importance in the geographic areas they serve. All of these adjustments are made based on the characteristics of the hospital as a whole. Any hospital conforming to the characteristics of a class of hospital identified for special treatment is eligible to receive such adjustments.

In the ambulatory care context, Medicare should move toward an approach that recognizes variation in the costliness of resources needed to provide services to different beneficiaries. That is, payment for the same service should be the same regardless of where it is provided; any deviations from equal payment should reflect differences in patient characteristics. The acute ICD-9-CM diagnosis code that is entered on the ambulatory care claim is not appropriate for making such adjustments, however, given concerns about the validity of these data on historical claims, and the lack of explicit reporting rules under the proposed system. Instead, MedPAC recommends that HCFA evaluate the relationship between more immutable patient characteristics (for example, certain chronic conditions or other physiological characteristics) and their effects on the cost of providing care.

Beneficiary coinsurance

One artifact of prior law payment policy governing hospital outpatient services is that beneficiaries are liable for nearly 50 percent of the total payment to hospitals for these services, compared with 20 percent for most other Medicare covered services.[7] The disproportionate beneficiary share for hospital outpatient services stems from calculating coinsurance as 20 percent of charges, while the program share is calculated as the lesser of costs or charges (or a blend, where applicable) net of the beneficiary copayment. Since hospitals' charges are generally much higher than their costs, beneficiaries are responsible for a larger share of the total payment. The BBA addresses this issue, but provides for only a very gradual reduction in beneficiary coinsurance.

RECOMMENDATION 6I

The Secretary should seek, and the Congress should pass, legislation to increase the rate of the beneficiary coinsurance buy-down. The cost of the faster buy-down

7 There is no beneficiary coinsurance for home health services or clinical laboratory services.

should be financed by increases in program spending, rather than through additional reductions in payments to hospitals.

The BBA will begin to reduce the beneficiary coinsurance by manipulating the shares of payments under the outpatient PPS. When a prospective rate is calculated for a given service (or, in the case of HCFA's proposal, a group of services), the beneficiary and program shares of the rate are calculated based on the composition of prior law payments for the service (see Table 6-4).

The approach to calibrating beneficiary coinsurance for hospital outpatient services outlined in the BBA is methodologically sound. However, as the buy-down could take decades to phase in completely. MedPAC believes that the coinsurance reduction should occur at a faster rate than under the BBA's provisions, preferably with a certain date of completion. Moreover, the cost of the faster buy-down should be financed by corresponding increases in program spending, rather than through additional reductions in payments to hospitals.

The cost of a more rapid buy-down would be significant, and, some might argue, unnecessary, because most Medicare beneficiaries have some sort of supplemental insurance that insulates them from the direct coinsurance liability (PPRC 1997). However, MedPAC believes that beneficiary coinsurance for hospital outpatient services has been a driving force in the recent double-digit increases in Medigap insurance premiums that have occurred in recent years. While the implementation of outpatient PPS will eliminate the continuing incentive for hospitals to increase their charges, Medigap premiums will likely continue to rise as insurers bring their revenues and expenditures into actuarial balance. Additionally, the continued disproportionate coinsurance liability will continue to severely affect the 13 percent of the Medicare beneficiary population who do not have secondary coverage when they receive ambulatory services in hospital OPDs.

Recommendation specific to the prospective payment system for ambulatory surgical centers

Finally, MedPAC presents a single recommendation regarding HCFA's implementation of changes to the ASC payment system.

HCFA proposes to reduce the importance of the site of service criteria discussed above that have historically been used to determine whether Medicare would cover a surgical procedure in ambulatory surgical centers. Additionally, the agency proposes to modify guidelines regarding

Beneficiary coinsurance buy-down

TABLE 6-4 Hypothetical example of coinsurance buy-down for cataract extraction with intraocular lens insertion

	1996	1997	1998	1999	....	2012	2013
Rate	$1,100.00	$1,155.00	$1,212.75	$1,273.39	. . .	$2,401.16	$2,521.22
Beneficiary	506.00	506.00	506.00	506.00	. . .	506.00	506.00
Program	594.00	649.00	706.75	767.39	. . .	1,895.16	2,015.22
Beneficiary share	46.0%	43.8%	41.7%	39.7%	. . .	21.1%	20.1%
Program share	54.0%	56.2%	58.3%	60.3%	. . .	78.9%	79.9%
Update Percent	5	5	5	5	. . .	5	

The Medicare Payment Advisory Commission (MedPAC) estimated the average hospital payment for cataract extraction with intraocular lens insertion at slightly over $1,100 in 1996, of which the program payment made up roughly 54 percent ($594) and the beneficiary coinsurance 46 percent ($506). If we use these rates and percentages to represent the effective rates at the outset of the outpatient prospective payment system (PPS), we can estimate the effects of the Balanced Budget Act (BBA) provision.

Assume a 5 percent annual update to the payment rates. In the second year of the PPS, then, the unadjusted payment rate for cataract surgery would be $1,155. In order to "buy down" the beneficiary coinsurance percentage, the BBA directs that the beneficiary coinsurance be held constant at the original dollar amount, until the beneficiary coinsurance equals 20 percent of the unadjusted PPS rate. In this example, in the second year, the beneficiary coinsurance would still be $506. In the second year, then, the beneficiary coinsurance falls from 46 percent to 44 percent of the Medicare payment. This trajectory continues until the coinsurance is equal to 20 percent of the payment rate, at which time it begins to increase along with the rate update. Under these assumptions, it would be 17 years before this point is reached.

length of operative time, time under anesthesia, and recovery time that have been used to assess coverage of surgical procedures in ASCs.

RECOMMENDATION 6J

The Secretary should carefully monitor changes in service provision between the ASC and physician office setting that may occur after HCFA's loosening of numerical guidelines for determining ASC list eligibility.

MedPAC supports the notion that beneficiaries, with their physicians, should be able to select the most appropriate setting for their care. If ASCs can safely provide certain ambulatory surgeries that were previously excluded from the ASC list due to the limitations described above, the coverage changes proposed by HCFA could improve beneficiary access to these services.

However, as we noted previously, because of the historical development of Medicare's various ambulatory care payment systems, Medicare's reimbursement for similar services usually differs by setting, often without a specific rationale. This discrepancy creates financial incentives that could affect the choice of setting. In practice, these incentives do not appear to have had a large effect, partly because of standards of appropriate medical practice, but also because of the strength of Medicare coverage regulations.

As coverage rules governing ASC services are loosened, services could more easily, and sometimes inappropriately, shift from other settings. The Commission is concerned that such shifts might increase costs to the program or to beneficiaries, or compromise the quality of the care beneficiaries receive. The Commission recommends that revisions to the ASC payment system be more explicitly tied to concurrent changes to Medicare's hospital outpatient and physician payment systems. Additionally, we reiterate that use of ambulatory care services should be carefully monitored once these changes are put into effect. ■

References

Carter G, Newhouse JP, Relles D. How much change in the case mix index is DRG Creep? Santa Monica (CA), The RAND Corporation. Report to the Health Care Financing Administration under cooperative agreement No. R-3826. April 1990.

Carter G, Newhouse JP, Relles D. Has DRG Creep crept up? Santa Monica (CA), The RAND Corporation. Report to the Health Care Financing Administration and ProPAC under cooperative agreement No. R-4098. 1991.

Health Care Financing Administration, Department of Health and Human Services. Medicare program: prospective payment system for hospital outpatient services. Federal Register. September 8, 1998a, Vol. 63, No. 173, p. 47552-48036.

Health Care Financing Administration, Department of Health and Human Services. Medicare program: update of ratesetting methodology, payment rates, payment policies and the list of covered surgical procedures for ambulatory surgical centers effective October 1, 1998. Federal Register. June 12, 1998b, Vol. 63, No. 113, p. 32290-32521.

Health Care Financing Administration, Department of Health and Human Services. Health care financing review, Medicare and Medicaid statistical supplement, 1996, No. 03386. Baltimore, HCFA. October 1996.

Medicare Payment Advisory Commission. Report to the Congress: Medicare payment policy volume 1. Washington (DC), MedPAC. March 1998a.

Medicare Payment Advisory Commission. Report to the Congress: context for a changing Medicare program. Washington (DC), MedPAC. June 1998b.

Miller ME, Sulvetta MB. Understanding the growth of Medicare hospital outpatient department services. Washington (DC), The Urban Institute. 1994.

Office of the Inspector General, Department of Health and Human Services. Review of ambulatory surgical services performed in hospital outpatient departments– procedure coding differences, No. A-01-94-0507. Washington (DC), OIG. December 1994.

Office of the Inspector General, Department of Health and Human Services. Problems with coding of physician services: Medicare part B, No. OAI-04-88-00700. Washington (DC), OIG; February 1989.

Physician Payment Review Commission. Annual report to the Congress. Washington (DC), PPRC. 1997.