

**Medicare Fee-For-Service  
Payment Policy Across Sites of Care**

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Statement of

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Chairman Pitts, Ranking Member Pallone, distinguished Committee members. I am Mark Miller, executive director of the Medicare Payment Advisory Commission (MedPAC). I appreciate the opportunity to be here with you this morning to discuss the Commission's views of Medicare payment policies across different sites of care.

The Medicare Payment Advisory Commission is a Congressional support agency that provides independent, nonpartisan policy and technical advice to the Congress on issues affecting the Medicare program.

## **Introduction**

The Commission's goal is to achieve a Medicare program that ensures beneficiary access to high-quality care, pays health care providers fairly, rewards efficiency and quality, and spends tax dollars responsibly. When we examine Medicare's payment policies across different sites of care, we observe several opportunities for policy development. In the testimony that follows, I will present the Commission's work on price differences across settings for ambulatory care and post-acute care (PAC), as well as the use of standard patient assessment tools and other payment policies to encourage care coordination in PAC.

In other Commission products, we provide important information and recommendations about setting payments in Fee-For-Service (FFS) Medicare to the level of the efficient provider and revising the payment systems to make them more equitable among providers.

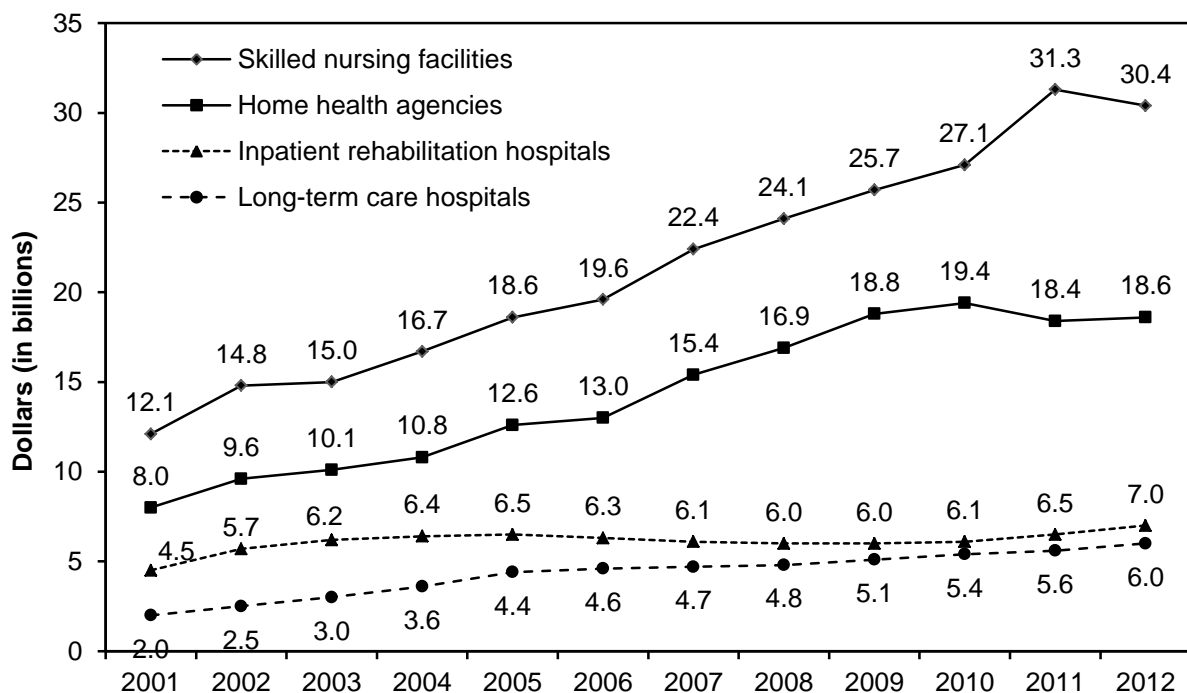
## **Background on post-acute care**

Post-acute care providers offer important recuperation and rehabilitation services to Medicare beneficiaries after an acute hospital stay. PAC providers include skilled nursing facilities (SNFs), home health agencies (HHAs), inpatient rehabilitation facilities (IRFs), and long-term care hospitals (LTCHs). As with any service, the Commission's goal is to recommend policies related to payments for PAC providers that ensure beneficiaries receive medically necessary, high-quality care in the least costly setting appropriate for their condition.

In 2012, about 41 percent of Medicare beneficiaries discharged from prospective payment system (PPS) hospitals went to a PAC setting. Of those, half went to SNFs, 39 percent received

home health care, and the remainder went to other settings, including IRFs and LTCHs. While almost all beneficiaries admitted to SNFs, IRFs, and LTCHs have a prior hospital stay, two-thirds of home health episodes are admitted directly from the community. In 2012, PAC FFS spending totaled \$62 billion and accounted for 17 percent of FFS spending. As shown in Figure 1, spending has increased for each PAC setting, with total PAC FFS spending more than doubling from 2001 to 2012. Over the same period, per beneficiary PAC FFS spending more than doubled as well.

**Figure 1. Medicare’s total FFS spending on post-acute care has more than doubled since 2001**



Note: These numbers are program spending only and do not include beneficiary cost sharing.

Source: CMS Office of the Actuary.

The Commission has repeatedly noted the shortcomings of Medicare’s FFS payment systems for PAC and the clear need for reforms. In many cases, payments are set too high relative to providers’ cost to treat Medicare patients. High Medicare margins and rapid entry of certain PAC providers into the program over the last decade are indications of potential financial opportunity in Medicare. Furthermore, the PPSs encourage providers to furnish certain services to boost payments or admit certain kinds of patients based on profitability. Although CMS has adopted

setting-specific rules to delineate the types of patients appropriate for IRFs and LTCHs, there is overlap in the types of patients treated in different settings. Because Medicare pays significantly different rates across settings, treating similar patients in different settings can unnecessarily increase program spending.

Though Medicare payments for PAC must be reformed, making improvements is challenging for several reasons. First, the need for PAC is not well defined; some patients can go home from the hospital without it, while others need it but receive varying amounts of service in different settings. Still others remain in the acute care setting a few days longer and avoid PAC altogether. The amount and type of PAC a patient receives is highly dependent on providers' practice patterns. While Medicare rules (conditions of participation and payment and coverage rules) provide some guidance regarding placement in PAC, providers of PAC have considerable latitude in terms of which patients they admit among the patients referred to them by hospitals. The Commission and others have documented the similarity of patients treated in different PAC settings. Reflecting this ambiguity, Medicare service use (as measured by per-capita spending adjusted for prices and health status) of PAC varies more than most other covered services. Service use in the geographic area at the 90<sup>th</sup> percentile is more than twice that of the area at the 10<sup>th</sup> percentile for PAC, while it is only about 20 percent higher for acute inpatient and ambulatory service use. At the extremes, PAC utilization varies by nearly a factor of eight. The range in service use indicates opportunities for more effective purchasing of PAC services by the Medicare program (Table 1).

**Table 1. Comparison of service use variation across geographic areas**

<b>Ratio of high to low service-use areas</b>	<b>Inpatient hospital</b>	<b>Ambulatory care</b>	<b>Post-acute care</b>
Areas at the 90th to 10th percentiles	1.22	1.24	2.01
Highest use to lowest use area	1.59	2.01	7.97

Note: Areas are defined as metropolitan statistical areas for urban counties and rest-of-state nonmetropolitan areas for nonurban counties. Service use is measured as risk-adjusted per capita spending (adjusted for wages and special add-on payments) by sector among fee-for-service beneficiaries in each area.

Source: MedPAC analysis of 2006–2008 beneficiary-level Medicare spending from the Beneficiary Annual Summary File and Medicare inpatient claims.

Second, PAC providers treat similar types of patients, yet Medicare pays different prices depending on the setting. For example, patients recovering from strokes and hip replacements are treated in IRFs and SNFs, but Medicare’s payments per stay to IRFs are 25 to 40 percent higher than its payments to SNFs for these conditions.

Further complicating reform efforts are utilization patterns that do not reflect efficient care. There are no financial incentives for hospitals to refer patients to the most efficient or effective setting, so actual PAC use does not indicate where patients would best receive their care or how much care is optimal. Instead, placement decisions can often reflect the availability of PAC settings in a local market (and whether there is an available bed), the hospital’s and family’s proximity to PAC providers, patient and family preferences, or financial relationships between providers (for example, a hospital may prefer to discharge patients to providers that are part of its system or those with whom it contracts).

**Table 2. Medicare spending on post-acute care varies more than three-fold for conditions that often use these services**

Condition	Spending on post-acute care within 30 days of hospital discharge			Ratio of 75th to 25th percentiles
	Mean	25th percentile	75th percentile	
Coronary bypass w cardiac catheterization	\$5,286	\$1,864	\$6,913	3.7
Major small & large bowel procedures	\$6,100	\$2,110	\$8,804	4.2
Major joint replacement	\$8,152	\$3,890	\$11,484	3.0
Stroke	\$13,914	\$5,936	\$19,371	3.3
Simple pneumonia & pleurisy	\$7,039	\$2,351	\$10,785	4.6
Heart failure & shock	\$5,997	\$2,034	\$9,331	4.6
Fractures of hip & pelvis	\$11,688	\$8,213	\$14,427	1.8
Kidney & urinary tract infections	\$8,040	\$3,335	\$11,963	3.6
Hip & knee procedures except major joint replacement	\$13,608	\$10,526	\$16,498	1.6
Septicemia or severe sepsis w/o MV 96+ hours	\$8,282	\$3,344	\$11,744	3.5
	Average of 10 conditions			3.2

Note: Post-acute care includes services furnished by home health agencies, skilled nursing facilities, inpatient rehabilitation facilities, and long-term care hospitals. We risk adjusted spending using Medicare severity–diagnosis related groups (MS–DRGs) and standardized payments for differences in wages and special payments (such as teaching, disproportionate share, and outlier payments). Data shown are for patients assigned to MS–DRG acuity level 1 (no complications or comorbidities). Spending is for care furnished within 30 days after discharge from an inpatient hospital stay.

Source: Medicare Payment Advisory Commission. 2013. *Report to the Congress: Medicare and the Health Care Delivery System*. Washington, DC: MedPAC.

Even among beneficiaries who used PAC and had similar care needs, Medicare spending on PAC varies more than three-fold (Table 2). These spending differences reflect the mix of post-acute care services (e.g., whether the beneficiary went to a SNF or an IRF) and amount of PAC used (e.g., the number of SNF days or home health care episodes).

Given the wide variation in spending and service use, it is critical that Medicare and its beneficiaries compare the efficacy of services provided in different settings. The Commission has discussed policy options in three areas to align Medicare policy across settings in post-acute care: (1) using a standardized assessment tool, (2) establishing site neutral payments across PAC settings, and (3) applying similar incentives across settings for care coordination.

### **Standardized Assessment Tool**

Medicare requires three of the PAC settings (HHAs, SNFs, and IRFs) to use setting-specific patient assessment tools in determining a patient's resource requirements. Although the tools cover similar information areas, each tool asks different questions, defines the activities being assessed differently, uses different scales to gauge patient functional status, and assesses patients over varying time frames. LTCHs are not required to submit comprehensive patient assessment information at admission and discharge.

The lack of comparable information undermines our ability to fully evaluate whether patients treated in different settings are, in fact, the same or whether one PAC setting is more appropriate than another for patients with specific conditions. Furthermore, without comparable information, we cannot systematically evaluate the cost and outcomes of the care that beneficiaries receive across settings. Providers may look more efficient or more able to achieve better outcomes, when actually, they treat less complex cases. Adequate risk adjustment is critical to making fair comparisons across providers and giving beneficiaries accurate information about high-quality providers. Common assessment items would gather comparable outcomes data to enable adjusting payments and outcomes to reflect differences across patients. Knowing which sites produce the best outcomes for each condition could be used to inform PAC placement decisions

and could possibly serve as evidence for Medicare to refine its coverage policies for these services.

Despite the need for standardized information across PAC settings, the Medicare program has been slow to implement the collection of common assessment information. In 1999, MedPAC called for the Secretary of Health and Human Services (HHS) to collect a core set of patient assessment information across all PAC settings. In 2005, the Deficit Reduction Act required a demonstration to develop and test a tool to collect that information. Medicare successfully developed, validated, and tested a tool called the Continuity Assessment Record and Evaluation (CARE) tool, and this process demonstrated its feasibility and acceptability. The results of this demonstration were reported to the Congress in 2012. Given these findings, and the urgency of moving forward with payment reforms, the Commission has recommended that Congress direct the Secretary to implement common patient assessment items for use in HHAs, SNFs, IRFs, and LTCHs by 2016.

### **Reforms to eliminate price differences across sites of care**

As mentioned above, providers treat similar types of patients, yet Medicare pays different prices depending on the site of care. The Commission holds that payment for the same set of services should be comparable regardless of where the services are provided to help ensure that beneficiaries receive appropriate, high-quality care in the least costly setting consistent with their clinical conditions. Within PAC, the Commission has focused on payment differences between SNFs and IRFs, and LTCHs and acute care hospitals. In each case, the Commission has developed a set of criteria to identify patients with similar care needs to guide the establishment of payment policy.

### **Patients with similar care needs in SNFs and IRFs**

Two PAC settings where certain groups of patients with similar care needs are treated are SNFs and IRFs. In the forthcoming *June Report to Congress*, the Commission compares Medicare payments for three conditions frequently treated in both settings. Because there is some overlap in the patients treated in both settings, yet payments can differ, there is a need to develop site-neutral policies that eliminate unwarranted payment differences. The Commission is not alone in

its interest in aligning payments between IRFs and SNFs. Since 2007, administrations' proposed budgets under presidents from both parties have included proposals to narrow prices between IRFs and SNFs for select conditions commonly treated in both settings.

The services typically offered in IRFs and SNFs differ in important ways. IRFs are required to meet the conditions of participation for acute care hospitals, including having more nursing resources available and having care supervised by a rehabilitation physician, among other requirements. Stays in IRFs are shorter on average and patients in IRFs receive more intensive services, in part because patients admitted must be able to tolerate and benefit from an intensive therapy program. The Commission recognizes that the services in the two settings differ; rather, it questions whether the program should pay for these differences when the patients admitted, and the outcomes they achieve, are similar.

Using several criteria, we selected three conditions frequently treated in IRFs and SNFs—patients receiving rehabilitation therapy after a stroke, major joint replacement, and other hip and femur procedures (such as hip fractures)—and assessed the feasibility of paying IRFs the same rates as SNFs for these conditions. We examined the characteristics of patients admitted to SNFs and IRFs and did not find large differences, especially for the orthopedic conditions, but there was more variation across the stroke patients. There was considerable overlap of risk scores, ages, comorbidities, functional status at admission, and predicted costs for therapy and nontherapy ancillary services (such as drugs). The average functional status at admission and patients' comorbidities overall did not differ substantially and the two settings admitted similar shares of dual-eligible and minority beneficiaries.

Differences in outcomes between IRFs and SNFs were mixed: unadjusted measures showed larger differences between the settings, and risk-adjusted measures generally indicated small or no differences between the settings. IRFs had lower observed readmission rates compared with SNFs for the three conditions, but with risk adjustment, CMS analysis found no statistically significant differences between the sites in rates of rehospitalization or changes in mobility. The unadjusted mortality rates during the 30 days after discharge were higher for patients who went to SNFs compared with patients who went to IRFs. Spending in the 30 days after discharge was higher for IRF patients than for SNF patients, due primarily to higher spending on other PAC



services such as SNF and home health care.

For the three conditions, we found that if IRFs were paid at the SNF rates, their aggregate payments for the three select conditions would decline. The industry-wide impact on total payments could be mitigated because IRFs would continue to receive IRF payments for the majority of their cases. The site-neutral policy could also be structured to maintain the add-on payments many IRFs receive for the select conditions. The impact of this policy was consistent across different types of IRFs (e.g., for-profit, non-profit). Although certain types of providers have higher shares of site-neutral cases, they also tend to have higher add-on payments that dampen the impact of a site-neutral policy.

If payments for select conditions were the same for IRFs and SNFs, the Commission believes that Medicare should consider waiving certain regulations for IRFs when treating site-neutral cases to level the playing field between IRFs and SNFs. Waiving certain IRF regulations would allow IRFs the flexibility to function more like SNFs when treating comparable cases.

Selecting a handful of conditions to study allowed us to explore potential for site-neutral payments between IRFs and SNFs. We found that the patients and outcomes for the orthopedic conditions were similar and represent a strong starting point for a site-neutral policy. Patients receiving rehabilitation care after a stroke were more variable, and we conclude that additional work needs to be done to more narrowly define those cases that could be subject to a site-neutral policy and those that could be excluded from it.

### **Care for Chronically Critically Ill Patients in LTCHs and Acute Care Hospitals**

Care for chronically critically ill patients is a second area of care within PAC where the Commission has observed patients with similar care needs receiving care in different settings. LTCHs have positioned themselves as providers of hospital-level care for long-stay chronically critically ill (CCI) patients—patients who typically have long, resource-intensive hospital stays often followed by post-acute care—but nationwide most CCI patients are cared for in acute care hospitals, and most LTCH patients are not CCI.

Medicare pays LTCHs under a separate PPS, with higher payment rates than those made for similar patients in the acute care hospital. There are few criteria defining LTCHs, the level of

care they provide, or the patients they treat. The Commission and others have repeatedly raised concerns that the lack of meaningful criteria for admission to LTCHs means that these providers can admit less-complex patients who could be cared for appropriately in less-expensive settings. Comparatively attractive payment rates for LTCH care have resulted in an oversupply of LTCHs in some areas and may generate unwarranted use of LTCH services by patients who are not CCI.

The effect of the disparity in Medicare's payments across settings for the most medically complex patients is exacerbated because such cases often are unprofitable in acute care hospitals paid under the IPPS. In areas with LTCHs, acute care hospitals may be able to reduce the costs of caring for some types of cases by transferring them earlier in the course of illness. In areas without LTCHs, acute care hospitals may have to keep these cases longer—and therefore accrue additional costs—until the patients are stable enough to be transferred to a lower level of post-acute care.

The Commission has raised questions about what Medicare is purchasing with its higher LTCH payments. Studies comparing LTCH care with that provided in acute care hospitals have failed to find a clear advantage in outcomes for LTCH users. At the same time, some studies have found that, on average, episode payments are higher for beneficiaries who use LTCHs. In addition, some studies have found that per episode spending may be the same or lower for the most medically complex patients who use LTCHs but not for those who are less severely ill.

The Commission's approach to reforming the LTCH PPS and aligning payment for CCI cases across settings is based on the premise that the most medically complex patients have always been a small share of the total population of hospital inpatients. Although hospital case mix has increased over time, the explosive growth in the number of LTCHs that followed implementation of the PPS was not driven by a need for these services but rather by payment policies that created opportunities for financial gain.

To reduce incentives for LTCHs to admit lower acuity patients—who could be appropriately cared for in other settings at a lower cost to Medicare—the Commission recommended in our March 2014 *Report to Congress* that standard LTCH payment rates be paid only for LTCH patients who meet the CCI profile at the point of transfer from an acute care hospital. LTCH cases that are not CCI would be paid acute care hospital rates approximately the same as MS—

DRG payment rates they would have been paid if the patient had been treated in an acute care hospital in the same local market. Funds that would have been used to make payments under the LTCH payment system instead should be allocated to the IPPS outlier pool to help alleviate the cost of caring for extraordinarily costly CCI cases in acute care hospitals.

The Commission recommends that—in the absence of data on the metabolic, endocrine, physiologic, and immunological abnormalities that characterize the CCI condition—Medicare should define LTCH CCI cases as those who spent eight or more days in an intensive care unit (ICU) during an immediately preceding acute care hospital stay. The Commission also recommended that an exception to the eight-day ICU threshold be made for LTCH cases that received mechanical ventilation for 96 hours or more during an immediately preceding acute care hospital stay. These types of cases are generally considered appropriate for admission to LTCHs and generally viewed as warranting higher LTCH-level payment rates.

## **Reforms that promote care coordination**

Over the last several years, Medicare has begun moving towards paying providers differentially for the quality of care they provide and the success of their care coordination efforts. The efforts began with a focus on inpatient hospitals and have begun to expand to other provider types. If value-based payment policies are not applied to all providers who are involved in treating Medicare patients, Medicare may not achieve the quality or care coordination outcomes it desires.

### **Expand readmission policies to PAC providers in FFS**

Based on analysis of the sources of variation in Medicare spending across episodes of care, in 2008 the Commission recommended that hospitals with relatively high readmission rates should be penalized. As of October 2012, a readmission policy now penalizes hospitals with high readmission rates for certain conditions.

In 2011, the Commission began to examine expanding readmission policies to PAC settings to reduce unnecessary rehospitalizations and better align hospital and PAC incentives. If hospitals and PAC providers are similarly at financial risk for rehospitalizations, they would have a stronger incentive to coordinate care between settings. In addition to minimizing the risks that

unnecessary hospital stays pose for beneficiaries, rehospitalizations raise the cost of episodes. Among 10 conditions that frequently involve PAC, we found Medicare spending for episodes with potentially preventable rehospitalizations was twice as high as episodes without them. Readmissions accounted for one-third of the episode spending. Furthermore, there is large variation in readmission rates, suggesting ample opportunity for improvement. For example, SNF rehospitalization rates for five potentially avoidable conditions vary by more than 60 percent between the best and worst facilities; hospitals' potentially preventable readmissions rates vary even more.

Aligned readmission policies would hold PAC providers and hospitals jointly responsible for the care they furnish. In addition, the policies would discourage providers from discharging patients prematurely or without adequate patient and family education. Aligned policies would emphasize the need for providers to manage care during transitions between settings, coordinate care, and partner with providers to improve quality. By creating additional pressure in the FFS environment, the policies would also create incentives to move to bundled payments or ACOs.

To increase the equity of Medicare's policies towards providers who have a role in care coordination, the Commission has recommended payments be reduced to both SNFs and HHAs with relatively high risk adjusted readmission rates. The proposed readmissions reduction policies would be based on providers' performance relative to a target rate. Providers with rates above the target would be subject to a reduction in their base rate, while agencies below would not. Such an approach could encourage a significant number of agencies to improve, thereby achieving savings for the Medicare program through penalties and lower hospital readmissions. The proposed policies also seek to establish incentives for all providers to improve, without penalizing providers that serve significant share of low-income patients. To do so, providers' performance would be compared to other providers that serve a similar share of low-income patients.

The SNF readmissions reduction program was recommended in the Commission's March 2012 *Report to Congress*. In March 2014, as part of the Protect Access to Medicare Act of 2014, the Congress enacted a SNF value-based purchasing program beginning in fiscal year (FY) 2019,

which includes readmissions and resource use measures. The home health readmissions reduction program recommendation was published in the March 2014 *Report to Congress*.

### **Bundled payments**

Under bundled payments, Medicare would pay an entity for providing an array of services to a beneficiary over a defined period of time. In the case of PAC, the bundle could cover all PAC services following a hospitalization. This would put pressure on all the PAC providers involved in providing care an incentive to provide high quality care in the most efficient setting.

Given the wide variation in PAC use, such an approach could yield considerable savings over time by replacing inefficient and unneeded care with a more effective mix of services. Bundled payments could also give providers that are not ready or unable to participate in more global payment like ACOs a way to gain experience coordinating care spanning a spectrum of providers and settings, thus facilitating progress toward larger delivery system reforms.

The Commission recommended testing bundled payments for PAC services in 2008 and since then has examined a variety of bundle designs. In our June 2013 *Report to the Congress*, the Commission described the pros and cons of key design choices in bundling PAC services: which services to include in the bundle, the duration of the bundle, how entities would be paid, and incentives to encourage more efficient provision of care. Each decision involves tradeoffs between increasing the opportunities for care coordination and requiring providers to be more accountable for care beyond what they themselves furnish.

We also laid out possible approaches to paying providers, comparing an all-inclusive payment made to one entity with continuing to pay providers FFS. Though a single payment to one entity would create stronger incentives to furnish an efficient mix of services, many providers are not ready to accept payment on behalf of others and, in turn, pay them. Alternatively, providers could continue to receive payments based on FFS. To encourage providers to keep their spending low, a risk-adjusted episode benchmark could be set for each bundle, and providers could be at risk for keeping their collective spending below it. In establishing the spending benchmarks, current FFS spending levels may not serve as reasonable benchmarks given the FFS incentives to furnish services of marginal value. The return of any difference between actual spending and the benchmark could be tied to providers meeting certain quality metrics to counter the incentive to

stint on services. For beneficiaries, bundled payments should improve care coordination and reduce potentially avoidable rehospitalizations.

## **Background on ambulatory payment systems**

Ambulatory care refers to medical services performed on an outpatient basis, without admission to a hospital or other facility. Ambulatory care is provided in settings such as ambulatory surgical centers (ASCs), hospital outpatient departments (OPDs), and the offices of physicians and other health professionals. Medicare generally covers ambulatory care under Part B, but pays for it using setting-specific payment systems.

Payment rates often vary for the same ambulatory services provided to similar patients in different settings. Medicare sets payment rates for physician and other practitioner services in the fee schedule for physicians and other health professionals, also known as the physician fee schedule (PFS); payment rates for most OPD services in the outpatient prospective payment system (OPPS); and payment rates for ASC services in the ASC payment system.

When a service is provided in a practitioner's office, there is a single payment for the service. However, when a service is provided in a facility, such as an OPD or ASC, Medicare makes a payment to the facility in addition to the payment to the practitioner. For example, if a 15-minute evaluation and management (E&M) office visit for an established patient is provided in a freestanding practitioner's office, the program pays the practitioner 80 percent of the PFS (nonfacility) payment rate and the patient is responsible for the remaining 20 percent. If the same service is provided in an OPD, the program pays 80 percent of the PFS (facility) rate and 80 percent of the rate from the OPPS and the patient is responsible for 20 percent of both rates. As a result, Medicare typically pays much more when services are performed in an OPD, and the beneficiary has higher cost sharing. For example, in 2014 both the program and the beneficiary paid 116 percent more in an OPD than in a freestanding office for a level II echocardiogram.

Payment variations across settings need immediate attention because the billing of many ambulatory services has been migrating from freestanding offices to the usually higher paid OPD setting. Among E&M office visits, echocardiograms, and nuclear cardiology services, for example, the volume of services decreased in freestanding offices and increased in OPDs from

2010 to 2012 (Table 3). For example, the volume of echocardiograms in freestanding offices dropped by 9.9 percent from 2010 to 2012 but grew by 33.3 percent in OPDs. One of the factors driving this phenomenon is the rapid growth in hospital purchases of physician practices. According to data from the American Hospital Association Annual Survey of hospitals, the number of physicians and dentists employed by hospitals grew by 55 percent from 2003 to 2011. As billing of services shifts from freestanding offices to OPDs, program spending and beneficiary cost sharing increase without significant changes in patient care. To limit the incentive to shift cases to higher cost settings, there is a need to align OPD rates with freestanding office rates.

**Table 3. E&M office visits and cardiac imaging services are migrating from freestanding offices to OPDs, where payment rates are higher**

Type of service	Share of ambulatory services performed in OPDs, 2011	Per beneficiary volume growth, 2010-2012	
		Freestanding office	OPD
E&M office visits (CPTs 99201 through 99215)	10.7%	-2.3%	17.9%
Echocardiograms without contrast (APCs 269, 270, 697)	34.6	-9.9	33.3
Nuclear cardiology (APCs 377, 398)	39.0	-16.8	24.3

Note: E&M (evaluation and management), OPD (outpatient department), CPT (current procedural terminology), APC (ambulatory payment classification).

Source: MedPAC analysis of Standard Analytic Claims Files from 2010 and 2012

The trend of hospitals purchasing physician practices is also leading to higher spending by private plans outside of Medicare and higher cost sharing for their enrollees. Many articles in the press have documented this trend, including pieces in the Wall Street Journal, New York Times, and USA Today. In one example, from an August 2012 Wall Street Journal article titled *Same Doctor Visit, Double the Cost*, a patient found that his insurance plan paid \$1,605 for an echocardiogram after his cardiologist's practice was acquired by a hospital system—more than four times the amount paid by the plan when the practice was independent. The patient, who had a high deductible health plan, had to pay \$1,000 of this larger bill. According to the patient,

“Nothing had changed, it was the same equipment, the same room.” In another example, a patient who received a 20-minute exam in a hospital-owned practice was charged a \$500 facility fee in addition to the physician’s \$250 professional fee. In some cases, private plans have stopped paying the additional facility fee for routine office visits provided in hospital-owned entities.

## **Reforms to eliminate price differences across sites of care**

One way to address payment variations between freestanding offices and OPDs is to revise payment rates in the OPPS so that payments are equal whether a service is provided in a freestanding office or in an OPD. However, for many services, equal payment rates would fail to account for some important differences between freestanding offices and OPDs that can lead to higher costs in OPDs. First, hospitals incur costs to maintain standby capacity for handling emergencies. Medicare payments for emergency department services include these standby costs, and, therefore, hospitals should be paid more for these services. Second, for certain other services, patients treated in OPDs are sicker than patients receiving the same services in freestanding offices, and these sicker patients may require more resources. Third, the OPPS combines the cost of a primary service (such as a procedure) with ancillary services and supplies into a single payment to a greater degree than does the PFS. The PFS tends to pay separately for each component of a service. This difference in the packaging of services should be considered when comparing payment rates between settings.

Stakeholders have also argued that Medicare should pay more for all services in the OPD – not just emergency services – because hospitals incur higher overhead costs than freestanding offices. For example, hospitals must comply with more stringent building and life-safety codes. However, we believe that to be a prudent purchaser of medical care, Medicare should not pay more for a service when beneficiaries can safely obtain the same service in a lower cost setting. The Commission has consistently argued that an individual provider or sector’s higher costs is not an argument by itself for higher payments.

In order to account for legitimate differences between freestanding offices and OPDs, the Commission developed five criteria to identify services that are good candidates for setting OPD payment rates equal to freestanding office rates:



- Services are frequently performed in freestanding offices (more than 50 percent of the time). This indicates that these services are likely safe and appropriate to provide in a freestanding office. Also, the PFS payment rates for these services are sufficient to assure access to care.
- Services entail minimal packaging differences across payment systems (i.e., the payment rate includes a similar set of services).
- The services are infrequently provided with an emergency department (ED) visit when furnished in an OPD (such services are unlikely to have costs that are directly associated with operating an ED).
- Patient severity is no greater in OPDs than freestanding offices.
- The services do not have a 90-day global surgical code (CMS assumes that physicians' costs for these codes are higher when performed in a hospital than a freestanding office).

### **Equalizing Medicare payment rates across settings for E&M office visits**

In our March 2012 *Report to the Congress*, we focused on nonemergency E&M office visits because they are similar across settings. For these services, it is reasonable to equalize payment rates in the PFS and the OPDS because:

- Hospitals do not need to maintain standby capacity for E&M visits that are not provided in an ED
- The extent to which ancillary items are packaged with E&M services is similar across the PFS and OPDS. We estimate that ancillaries only add about \$2 to the payment rate of the average E&M visit provided in an OPD.

The Commission recommended that total payment rates for an E&M visit provided in an OPD should be reduced to the amount paid when the same visit is provided in a freestanding office, which is the lower cost setting.

### **Aligning payment rates between OPDs and physicians' offices for other types of ambulatory services**

In our June 2013 and March 2014 reports to Congress, the Commission examined other ambulatory services frequently performed in freestanding offices that receive higher Medicare

payments in OPDs. We found 66 categories of services that meet the criteria above. These are candidates for having their OPD payment rates aligned with the PFS rates. We classify these services into two categories:

- Group 1 includes 24 categories of services. These meet all five criteria and OPD payments rates would be set equal to freestanding office payment rates.
- Group 2 includes 42 categories of services. These meet four of the criteria, but have greater packaging of ancillary items in the OPDS than the PFS. The OPD rate would be set higher than the freestanding office rate, but the difference should be reduced from the current level. The higher price for OPD services would reflect only the cost of ancillary items that are packaged into the unit of payment in the OPDS but are paid separately in the PFS.

The Commission recommended that differences in payment rates between OPDs and freestanding offices be reduced or eliminated for these 66 service categories.

### **Equalizing payment rates between OPDs and ASCs for certain ambulatory surgical procedures**

We also explored a policy that would equalize payment rates between OPDs and ASCs for certain ambulatory surgical procedures. Medicare currently pays 81 percent more in OPDs than ASCs for the same procedure, and this payment gap has increased over time, influencing some ASC owners to sell their facilities to hospitals. Beneficiary cost sharing is also much greater in OPDs than ASCs. We identified 12 groups of services that are commonly performed in ASCs for which the OPD payment rates could be reduced to the ASC level. These services are infrequently provided with an ED visit when furnished in an OPD and have an average patient severity that is no greater in OPDs than in ASCs. Because the ASC payment system and the OPDS use the same rules for packaging ancillary items with the primary procedure, the unit of payment is the same in both settings.

### **Limiting Medicare revenue losses for hospitals that serve a large share of low-income patients**

Some hospitals may serve as the primary source of access for low-income Medicare patients. Therefore, policymakers may wish to consider a stop-loss policy that would limit the loss of

Medicare revenue for these hospitals. For example, one option is to base eligibility for such a policy on a hospital's percentage of Medicare inpatient days for patients who are eligible for Supplemental Security Income (SSI). Then, Medicare revenue losses for eligible hospitals could be limited to a specified percentage, e.g. 1 or 2 percent. Finally, policymakers could choose to make the stop loss policy temporary or permanent.

## **Conclusion**

The Commission has discussed and recommended many changes that would increase the value of Medicare's purchases and improve the coordination of care beneficiaries receive. Several of these policies could be implemented in the near-term and would serve as building blocks for broader payment reforms. In the future, the Commission envisions Medicare moving toward payment systems that are based solely on the needs of the patient, irrespective of the site of care, and that give providers greater accountability over the quality and cost of the care provided to Medicare beneficiaries.