Addressing Medicare payment differences across settings: Ambulatory care services

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Overview

- Multiple payment systems for ambulatory services
  - But similar patients receive similar services
- Payment rates vary across systems for same service
  - E.g., rate for laser eye procedure is 90% higher in outpatient department (OPD) than physician's office
- Raises program spending and beneficiary cost sharing

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Payment principles

- Patients should have access to settings that provide appropriate level of care
- Prudent purchaser should not pay more for a service in one setting than another
- Medicare should base payment rates on resources needed to treat patients in lowest-cost, clinically appropriate setting

Reasons why payment rates could differ by ambulatory setting

- Hospitals incur costs related to standby capacity and emergency care
- Differences in patient severity that may affect costs
- Differences in the unit of payment
  - E.g., OPD payment unit includes more ancillaries than physician fee schedule

Payment rates for ambulatory services often vary by setting

- OPD rates often higher than physician office rates
  - Some services are paid same (e.g., MRI, outpatient therapy, clinical lab tests)
- Shift of services from physicians' offices to OPDs
  - E.g., share of echocardiograms provided in OPDs grew from 22 percent in 2008 to 25 percent in 2010
- Recommendation to equalize rates for non-emergency E&M visits across settings (March 2012)

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Addressing payment variations for other ambulatory services

- We have evaluated other ambulatory services that have payment disparities between settings
- For some services, payments could be equal across settings
- For other services, payments could be higher in OPDs but the magnitude of the difference could be narrowed

Criteria for services that could have equal rates across settings

- Frequently performed in physicians' offices (more than 50% of time)
- Similar unit of payment (ancillaries are less than 5% of total cost of service in outpatient system)
- Infrequently provided with an ED visit (less than 10%)
- Minimal difference in patient severity across settings

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Services that meet potential criteria for equal rates across settings (Group 1)

- 25 Ambulatory Payment Classifications (APCs)
- Most are diagnostic tests, such as
  - Level II echocardiogram without contrast
  - Level II extended EEG, sleep, and cardiovascular studies
  - Bone density testing
  - Level II neuropsychological testing
- Some are procedures, such as laser eye surgery

Services for which payment differences could be narrowed (Group 2)

- 61 APCs
- Meet 3 of the 4 criteria for equal payments across settings
- But OPPS has more packaging of ancillaries than does the PFS
- OPPS rates could be set to
  - Amount needed for equal payments in OPDs and freestanding offices, plus
  - Cost to OPDs for additional packaging of ancillaries

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Summary of two groups

Group 1 (equal payments)	Group 2 (reduce differences)
> 50% in offices	> 50% in offices
< 5% packaging	> 5% packaging
< 10% in EDs	< 10% in EDs
Similar patient severity across settings	Similar patient severity across settings

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Setting OPPS rates for Group 1 (Example: laser eye procedures)

	Visit in office	Visit in OPD	
		Current rates	Limit on OPPS rate
Fee schedule rate	$389	$360	$360
OPPS rate	N/A	379	30
Total payment (Pct difference)	**389** **---**	**738** **(90%)**	**389** **(equal)**

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Note: Laser eye procedures are APC 247 in the outpatient prospective payment system.

Setting OPPS rates for Group 2 (Example: level I echocardiogram)

	Visit in office	Visit in OPD	
		Current rates	Limit on OPPS rate
Fee schedule rate	$143	$44	$44
OPD payment			
OPPS rate	N/A	275	99
Packaging	N/A	N/A	41
Total payment	**143**	**319**	**184**
(Pct difference)	**---**	**(123%)**	**(29% from pckg)**

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Note: Level I echocardiograms are APC 697 in the outpatient prospective payment system.

Aggregate policy effects (one year)

- Program spending would decline by $900 million
- Beneficiary cost sharing would decline by $250 million

Note: Estimates are preliminary and subject to change

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Effects of reducing OPD rates for both groups of service, by hospital category

Hospital group	Decline in overall revenue	Decline in OPD revenue
10th percentile	0.2%	1.4%
90th percentile	2.0	6.8
Urban	0.7	3.3
Rural	1.2	4.2
Major teaching	0.7	3.6
Other teaching	0.6	3.1
Non-teaching	0.8	3.5
Voluntary	0.7	3.4
Proprietary	0.7	3.5
Government	0.8	3.6
All hospitals	0.7	3.4

Note: Estimates are preliminary and subject to change

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Comparing 100 hospitals that would see largest payment reductions to all hospitals

Variable	100 hospitals w/ largest reductions	All hospitals
Avg loss	4.8%	0.7%
Median DSH pct	12.5	25.6
Pct major teach	7.0	8.3
Pct rural	24.0	28.9
Pct voluntary	39.0	59.4
Pct proprietary	58.0	24.3
Pct government	3.0	16.3

Note: Estimates are preliminary and subject to change

Characteristics of 100 hospitals that would see largest payment reductions

- Much smaller than average hospital
- 60 of top 100 are specialty hospitals
  - 47 of 60 are orthopedic/surgical hospitals, which tend to focus on outpatient care
  - Specialty hospitals less likely to have EDs
- ED visits much smaller share of Medicare revenue compared with other hospitals

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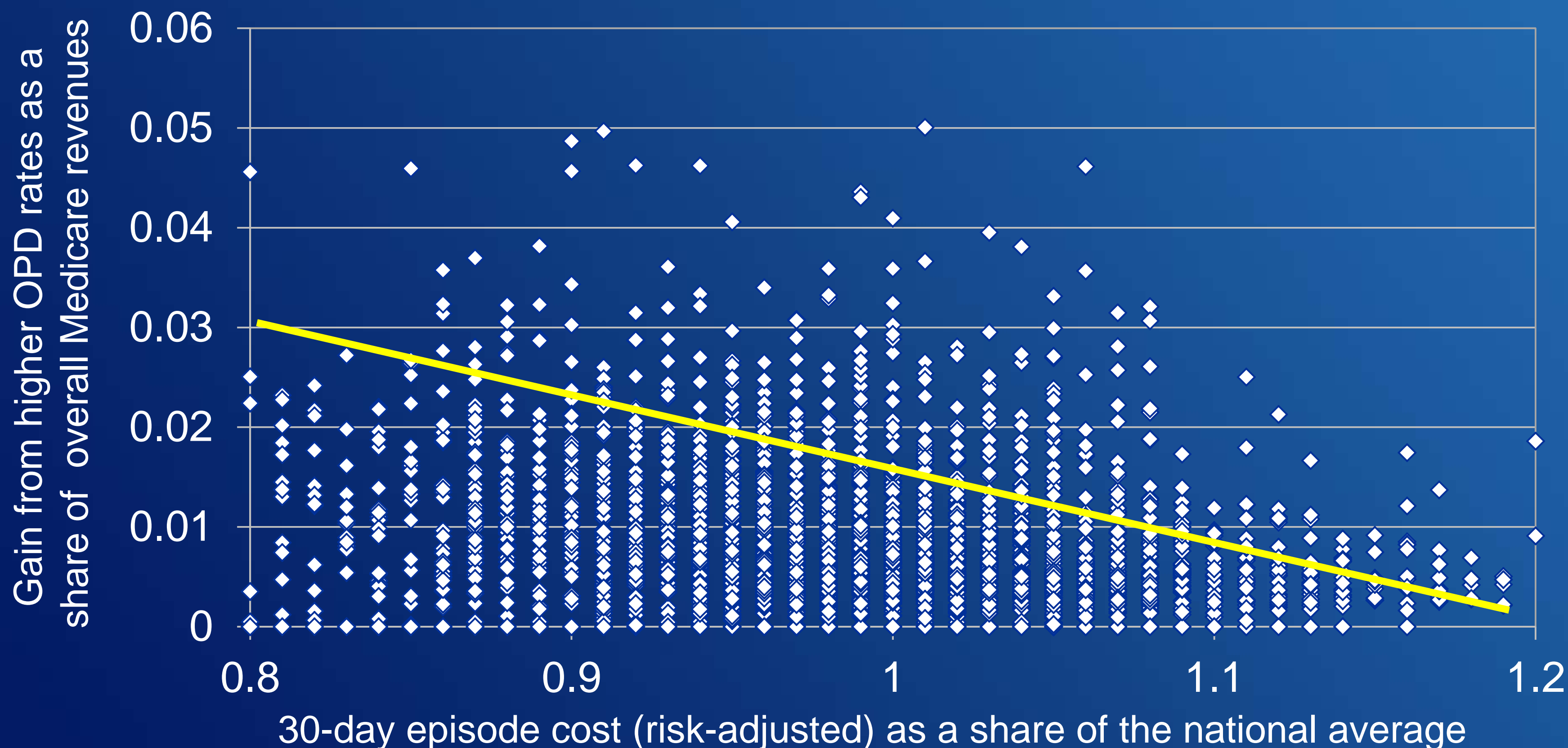
Other issues

- Using PFS rates as benchmark for OPD rates
  - Although we have concerns about access to primary care, overall access to PFS services is good (March 2012)
  - Commission recommendations to improve process for identifying misvalued services
  - Because of recommendations and other changes, payment rates for primary care have increased
- Do hospitals that benefit from higher OPD rates have lower Medicare spending per episode?

Weak relationship between hospitals' benefit from higher payments for certain outpatient services and episode costs



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Estimates are preliminary and subject to change

For Commission discussion

- Feedback on policy options to eliminate or reduce payment differences
- Differences across settings for services that are often provided with ED visit or have differences in patient severity
- Additional questions/research