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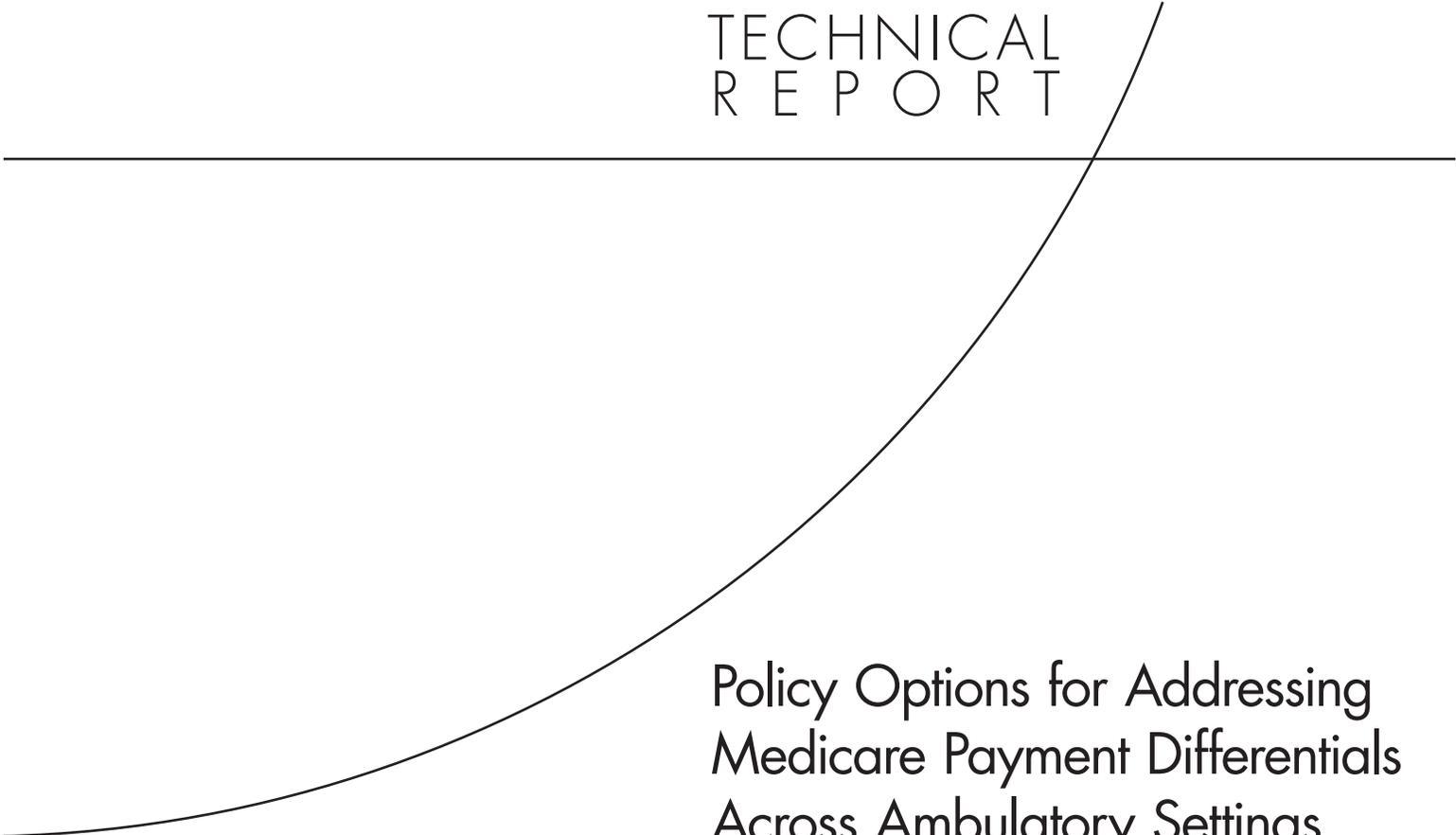
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Policy Options for Addressing  
Medicare Payment Differentials  
Across Ambulatory Settings

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Sponsored by the Assistant Secretary of Planning and Evaluation in the  
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## SUMMARY

This report analyzes potential options for modifying Medicare payment policies to improve the value of services provided in ambulatory settings. By *value*, we mean that comparable services with similar outcomes are delivered in a medically appropriate setting at an efficient price. We discuss policies that would seek to improve value by addressing the differential in the amount that Medicare pays for similar facility-related services in various ambulatory settings. The report draws on analyses undertaken by RAND for the Assistant Secretary of Planning and Evaluation in the U.S. Department of Health and Human Services examining payment and cost differentials for selected services that can be provided in multiple ambulatory settings. Our findings confirm that payments tend to be higher for services provided in hospitals than for those provided in physician offices (POs), but they also indicate that payment differentials generally exceed cost differentials and vary by procedure. These payment differences are generally attributable to how the payment systems have evolved and do not reflect differences in patient characteristics or the nature of the procedure across settings.

We grouped the policies to improve the value of services provided in ambulatory settings according to three types of policy changes:

- *Policies increasing uniformity in payment units and differentials.* A major challenge in addressing payment differentials across settings is the differences in the definitions of the units of service covered by a payment. A first step in addressing payment differentials would be to increase uniformity in how payments are defined by packaging the same set of services into the payment unit. A second step would be to standardize the differences across procedures so that the same differential applies to all procedures in a given category of service (e.g., diagnostic imaging). Generally, these are improvements in the payment system that do not have direct budgetary implications, but they lay the foundation for other policies to improve the value of services provided in ambulatory settings.
- *Policies addressing payment differentials.* The value of services provided in ambulatory settings could be increased by policies that either (1) tie payment differentials to justifiable cost differences between settings (thus creating neutral incentives in terms of where care is delivered) or (2) base payment on the amount payable in the least costly setting (thus creating incentives to shift care to the most efficient setting). These policies, which are not mutually exclusive, have implications not only for Medicare program expenditures and beneficiary

coinsurance payments but also for the ways in which hospital costs that are not tied to an individual patient—such as maintaining hospital standby and emergency services—should be recognized by Medicare. In the longer term, standardizing the unit of payment and the differentials by type of service provides a tool to systematically address payment differentials across settings. In the interim, there are immediate steps that could be taken, such as paying for services provided in hospital off-campus clinics at the rates for PO and ambulatory surgical center (ASC) services, establishing limits on hospital payments for diagnostic procedures that are commonly furnished in non-hospital settings, and limiting the amounts paid for services performed in a PO to the amount payable to hospitals.

- *Other policies to increase value.* In addition to addressing the payment differential across ambulatory settings, the study identified other policies that would improve the value of services provided to Medicare beneficiaries. Expanding the package of services included in the unit of payment would address the heterogeneity of services across settings and provide incentives to reduce unnecessary services. However, it could also create adverse incentives to skimp on medically needed services. Another policy would address a duplicate payment for practice expense that is made when office-based procedures are provided in an ASC; refining the ASC payment to exclude the duplicate payment would reduce the incentive to shift services from office-based settings to ASCs. Revising payment policies for separately billable anesthesia services provided during procedures whose payments include moderate sedation would also eliminate duplicate payments and, depending on how it was structured, create incentives to provide separately billed anesthesia only when medically necessary. Finally, informing providers and beneficiaries of the comparative costs both to beneficiaries and to Medicare of obtaining care in different venues could drive volume toward lower-cost settings, reducing costs to beneficiaries and Medicare.

Some policies to increase the value of ambulatory services could be implemented without further research or substantial policy development, though they may require statutory changes. Broader payment reform policies that were not examined in this study and that require more research include (1) bundling all services provided during an episode of care, (2) rationalizing payment for evaluation and management services in different settings, and (3) making performance-based incentive payments.

The role of payment differentials should be considered as policies are developed that introduce incentives to improve the quality and efficiency of care provided to Medicare beneficiaries. Such provisions are already in the Patient Protection and Affordable Care Act of 2010 (Pub. L. 11-148).<sup>1</sup> A challenge will be to exclude excessive payment differentials from the baseline for these programs. Doing so will ensure that measured savings are attributable to gains in delivering care more efficiently rather than payment differentials that do not reflect actual differences in the cost of providing care.

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<sup>1</sup> These provisions include the Medicare shared savings program for accountable care organizations (Section 3022), hospital value-based purchasing program (Section 3001), and physician fee schedule value-based payment modifier (Section 3007).