

WORKING P A P E R

Medicare Payment Differentials across Ambulatory Settings

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SUMMARY

Separate payment systems are used in each ambulatory setting where care is provided to Medicare beneficiaries: hospital outpatient departments (HOPDs), ambulatory surgical centers (ASCs) and physician offices (POs). For most services, Medicare pays different amounts for the facility-related component of providing comparable services in different settings. The payment differentials have raised questions about what types of potentially perverse financial incentives exist that could influence a provider's choice of ambulatory setting and whether Medicare is paying a premium for services that could appropriately be provided in a less costly setting (MedPAC, 2004).

PURPOSE

The Office of the Assistant Secretary for Planning and Evaluation asked RAND to analyze issues related to modifying Medicare payment policy for health care services delivered in various ambulatory settings so that payment rates reflect the costs of delivering the services in each setting. The study had three main objectives: (1) document the payment differentials for equivalent facility services provided to Medicare beneficiaries in different ambulatory settings; (2) inform the policy debate on whether the differentials reflect cost differences that should be accounted for in the payment systems; (3) develop potential policy options to reduce or eliminate inappropriate differentials.

STUDY DESIGN

The study was an exploratory analysis of the issues using a set of high-volume services that are performed in multiple ambulatory settings. We used the selected services to document at the procedure-code level the differences in the 2008 Medicare fee schedule *rates* across HOPDs, ASCs, and POs. These rate comparisons are indicative of the differences in Medicare payments across settings, but do not necessarily provide an accurate measure the *payment* differentials for some procedures because the definition of the items and services that are included in the unit of payment are not necessarily consistent across settings. We supplemented our analysis of Medicare payment differentials with an analysis of private insurance payment differentials for the study procedures. To explore differences in the costs of providing

services across settings, we drew on the available data and methods used in the hospital outpatient prospective payment system (OPPS) and physician fee schedule rate-setting processes to examine procedure-level cost differences in both total estimated cost and the percentage attributable to indirect costs. For ASCs, data limitations required that we take a different approach. We used administrative data and financial reports from ASCs collected by the California Office of Statewide Health Planning and Development to estimate an overall cost level that could be compared to HOPD cost level implicit in the OPPS conversion factor.

After documenting the payment and cost differentials across settings for the study procedures, our next task was to explore the factors beyond the rate-setting methodologies that might account for the differences. Based on a review of earlier studies, we identified four factors in addition to the underlying infrastructure differences that might explain differences in the cost of providing services: patient characteristics, accreditation and regulation, service content, and coding. We used an approach that combined analysis of data where possible and extensively supplemented these data with opinions of professionals providing the services selected for further study. We used a semi-structured interview approach to obtain this information.

Our selection of the study procedures and methodological approach was guided by a technical expert panel. We used the input of panel members and the findings from our interviews and cost analyses to frame the options for potential policy changes and to identify areas where additional research is needed.

SUMMARY OF FINDINGS

With the implementation of payment policy changes in 2008 that set ASC payment rates for most procedures at 67 percent of the amounts paid to ASCs, payment differentials have been largely standardized between HOPDs and ASCs. Some differentials remain because ASC services that are commonly furnished in POs are paid at the lower PO rate. The payment differential between HOPDs and ASCs will change over time due to different conversion factor update methods and separate budget-neutrality adjustments for recalibration of the relative weights. Payment rates for similar services vary widely between HOPD/ASCs and POs, with the size of the differential varying by service. Measuring these

differentials, however, is problematic because of differences in the related services that are packaged into the payment for a given procedure.

Private payer payment differentials are generally less than the Medicare payment differentials between HOPD and PO services. There are also substantial differences in the distribution of some of the study procedures across settings, with a higher percentage of non-Medicare patients receiving services in the PO setting and a lower percentage receiving services in the ASC setting.

Measurement of costs is extremely hampered by available data sources. Using the current fee schedule cost finding methods to compare HOPD and PO costs at the procedure-level, cost differentials between settings are also large, although smaller than the payment differentials. Payment differentials are larger than cost differentials chiefly because of budget neutrality provisions. Using California ASC data, the overall payment differential between HOPD and ASC costs appears roughly comparable to the cost differentials.

Our interviews and literature review found several differences between settings that may justify some of the observed cost and payment differentials. Patient comorbidity is seldom the primary reason for referral to HOPDs; patients receiving the study procedures are typically at low risk for adverse outcomes in all settings. However, patients requiring more resource-intensive procedures (e.g., additional equipment or medications) may be referred more frequently to the HOPD because the payment rate is perceived to be insufficient to cover the costs of providing care in the ASC/PO setting.

The physicians that we interviewed expressed a strong preference of the efficiency of ASCs relative to HOPDs, due to newer physical plants, shorter patient turnover time, dedicated resources in close proximity, as well as differences in "culture" that can promote slowness and inefficiency in the HOPD. The regulatory burden is much lower in POs than ASCs or especially HOPDs. However, HOPDs may benefit from being able to spread costs across more service lines. HOPDs also provide more charity care than ASCs and POs.

DISCUSSION

Our findings suggest that payment differentials between settings are large and variable among procedures to an extent that do not appear justified by factors we examined. What policies could be used to establish payment

differences consistent with "value-based" purchasing concepts? There is no obvious answer to this question. Indeed, the question raises several major policy issues:

- Medicare is paying more for services provided in HOPDs that could be appropriately provided in less resource-intensive settings. As a prudent buyer, when is it appropriate for Medicare pay more than the amount applicable to the "least costly" setting for comparable services?
- Policies that "level the playing field" across ambulatory settings could either decrease payments to HOPDs and/or increase payments to ASCs and POs. Under either approach, services are likely to shift to non-hospital settings and hospitals will face lower revenues for HOPD services that can be appropriately provided in other settings. What is likely to occur if hospitals lose their ability to cross-subsidize services that can only be provided in the hospital setting?
- While the differentials for particular services vary widely, they are an integral part of different payment systems for HOPD/ASC services on one hand and PO services on the other. Is it appropriate to deviate from site-specific fee schedules for particular services?

ADDRESSING ASC/HOPD PAYMENT DIFFERENTIALS

Payment differentials between ASCs and HOPDs have largely been standardized in 2008 but will begin to diverge because of differences in the update policies. There are several "tweaks" to the existing policy that could help to make payments more consistent with cost and maintain the relationship in the future.

- **Determine ASC conversion factor based on cost.** The ASC conversion factor was set at 67% of the OPPS conversion factor in order to be budget neutral with estimated ASC payments under the prior system. If ASC payment levels differ widely from actual ASC costs, it could lead to distortions in where services are provided. State databases containing both utilization and financial data could be used to measure differences in overall cost levels between the two settings.
- **Same update factor for ASC/HOPD.** Since ASCs and HOPDs will use different methods for updating the conversion factor, the payment differential (currently set at 67% on a budget-neutrality basis) will change over time in unpredictable ways. A legislative change to allow the same update factor would eliminate this source of variability in payment differentials between the two settings.
- **Maintain same OPPS/ASC relative weights over time.** The relative weights for OPPS procedures will be updated annually on a budget-neutral basis separately for HOPDs and ASCs. Consolidating the budget neutrality calculations or making the ASC budget neutrality adjustment to the conversion factor rather than the relative weights will preserve a consistent relationship between HOPD and ASC relative weights, but may also require legislative change.

ADDRESSING PO/HOPD PAYMENT DIFFERENTIALS

Payment differentials between POs and HOPDs are products of two different rate-setting approaches and are larger than between ASCs and HOPDs, so that addressing them would require more substantial policy changes. There are

several potential ways that PO/HOPD payments could be made more consistent, including:

- **Same bundling policies for PO as other settings.** A first step toward more consistent payments would be to apply the OPPS bundling rules to the PO setting to the extent practical. This may not be practical for two separate procedures involving two different physicians during the same encounter but should be feasible for items and supplies that are billed by the physician providing the service in a PO, such as contrast media and drugs that are bundled into the OPPS payment.
- **Consistent policies for multiple procedure discounting.** Discounting for imaging services applies only to services provided in the PO. The rationale for discounting is equally applicable to imaging services provided in the HOPD setting.
- **Reduce the differential for commonly performed PO services.** The payment differential between HOPDs and POs could be standardized for appropriate procedures, similar to how HOPD/ASC differentials were standardized. This could be done by blending the rates for HOPDs and POs or by capping the HOPD payment rates at a percentage of PO PE payment rates for services that could appropriately be performed in either setting and are not likely to vary in clinical content across settings. Either method could recognize the higher HOPD cost structure.

AREAS FOR ADDITIONAL RESEARCH

This exploratory study was performed using available data and a small set of study procedures chosen in part to maximize comparability. The interpretation of the results on payment and cost differentials is limited by differences in the comparability of services and methods between settings and by lack of a measure of efficient costs. The generalizability of the results is limited by the sample of study procedures. Further research could address these issues.

- **Comparability of services across settings.** Analysis of administrative data for services provided in physician offices and other non-facility settings is needed to inform the extent to which services that are bundled in the HOPD/ASC settings are separately paid in POs. This information is needed to fully understand the payment differentials between the settings. Analysis of 2008 or later utilization data would provide information on differences in the distribution of procedures within APCs between ASCs and HOPDs and whether there are differences in procedure mix between the two settings after the ASC policy changes are implemented.
- **Comparability of costs across settings.** Comparability of costs across settings could be addressed by conducting resource-based costing studies on selected procedures across all three settings. The findings from the non-Medicare payment analyses could be used to target candidate procedures.
- **Efficiency of care across settings.** While there is general agreement that Medicare should cover the costs of efficiently delivered care, there is no consensus on how to measure efficiency and the extent to which efficiency measures should consider not only cost but quality outcomes (McGlynn, 2008). The issue of whether ambulatory care is more efficiently delivered in one setting than another could be further addressed by expanding the unit of analysis to the episode of care that would include related services and follow-up care.

- **Generalizability.** Because one criterion in selecting the study procedures was that the procedures were unlikely to vary by patient characteristics and clinical content, our findings are not generalizable to the range of services provided in multiple ambulatory settings. Generalizability could be addressed by extending the analyses to more complex and invasive procedures.