

CHAPTER

2

**Medicare payment differences
across ambulatory settings**

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Chapter summary

Medicare's payment rates often vary for the same ambulatory services provided to similar patients in different settings, such as physicians' offices or hospital outpatient departments (OPDs). For example, in 2013, Medicare pays 141 percent more for a level II echocardiogram in an OPD than in a freestanding physician's office. These variations raise questions about how Medicare should pay for the same service when it is delivered in different settings.

If the same service can be safely provided in different settings, a prudent purchaser should not pay more for that service in one setting than in another. Payment variations across settings may encourage arrangements among providers that result in care being provided in higher paid settings, thereby increasing total Medicare spending and beneficiary cost sharing. In general, the Commission maintains that Medicare should base payment rates on the resources needed to treat patients in the most efficient setting, adjusting for differences in patient severity to the extent that severity differences affect costs.

Payment variations across settings urgently need to be addressed because many services have been migrating from physicians' offices to the usually higher paid OPD setting, as hospital employment of physicians has grown. This shift toward OPDs has resulted in higher program spending and

In this chapter

- How should Medicare pay for the same ambulatory services in different settings?
- Equalizing Medicare payment rates across settings for E&M office visits
- Aligning payment rates between OPDs and physicians' offices for other types of ambulatory services
- Aligning payment rates between OPDs and physicians' offices for cardiac imaging services
- Equalizing payment rates between OPDs and ASCs for certain ambulatory procedures

beneficiary cost sharing without significant changes in patient care. From 2010 to 2011, for example, the share of evaluation and management (E&M) office visits provided in OPDs increased by 9 percent, the share of echocardiograms provided in OPDs increased by 15 percent, and the share of nuclear cardiology tests in OPDs increased by 22 percent. If these three types of services continue to migrate to OPDs at the same annual rate from 2011 to 2021, Medicare spending would be \$2.3 billion higher per year by 2021, and beneficiary cost sharing would be \$590 million higher per year.

One way to address payment variations between physicians' offices and OPDs is to reduce payment rates in the outpatient prospective payment system (OPPS) so that payments are equal whether a service is provided in a freestanding physician's practice or in an OPD. However, for many services, equal payment rates would not account for some important differences between physicians' offices and OPDs that can lead to higher costs in OPDs. First, hospitals incur costs to maintain standby capacity for handling emergencies and to comply with additional regulatory requirements. Second, patient severity may be greater in OPDs, and it may cost more to treat sicker patients. Third, the OPPS is more likely than the fee schedule for physicians and other health professionals, also known as the physician fee schedule (PFS), to combine the cost of a primary service (such as a procedure) with ancillary services and supplies into a single payment. The PFS tends to pay separately for each component of a service. This difference in the packaging of services must be considered when comparing payment rates between settings. In our March 2012 report, we focused on nonemergency E&M office visits because they are largely unaffected by these differences between OPDs and freestanding offices. The Commission recommended that payment rates be equal whether an E&M office visit is provided in an OPD or in a freestanding office.

In this chapter, we examine other ambulatory services frequently performed in freestanding offices or ambulatory surgical centers (ASCs) that receive higher Medicare payments in OPDs. Although we explore options for reducing variations in payment rates across settings, we do not recommend payment changes in this chapter. We identified 66 groups of services provided in OPDs and freestanding offices that meet the Commission's principles for aligning payment rates across settings. Within each group, the services are frequently performed in physicians' offices, which indicates that they are likely safe and appropriate to provide in a freestanding office and that PFS payment rates are adequate to ensure beneficiaries' access; 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); have average patient severity that is no greater in

OPDs than in freestanding offices; and do not include 90-day global surgical codes.

We divided these services into two categories:

- Group 1 includes services for which payment rates could be the same whether they are provided in a freestanding office or in an OPD (because the level of packaging across payment systems is similar).
- Group 2 includes services for which the gap in payment rates between OPDs and freestanding offices could be narrowed but for which the OPD rate should remain higher to account for the higher level of packaging in the OPDS.

Changing OPD payment rates for the services in Group 1 and Group 2 would reduce program spending and beneficiary cost sharing by \$900 million in one year. Cost-sharing savings would range from \$140 million to \$380 million, depending on how OPDS copayments are determined. On average, hospitals' overall Medicare revenue would decline by 0.6 percent, and OPD revenue would fall by 2.7 percent.

An alternative policy would focus on aligning payment rates between OPDs and freestanding offices only for cardiac imaging services in Group 1 and Group 2—namely, echocardiography and cardiac nuclear tests. These services have been migrating rapidly from freestanding offices to OPDs as hospital employment of cardiologists has grown. In addition, payment rates are much higher when these services are provided in OPDs rather than offices. Reducing OPD payment rates for these cardiac imaging services would reduce program spending and beneficiary cost sharing by \$500 million in one year, with reduced cost sharing accounting for about \$100 million. On average, hospitals' overall Medicare revenue would decline by 0.3 percent, and OPD revenue would fall by 1.5 percent.

We also explored a policy that would equalize payment rates between OPDs and ASCs for certain ambulatory surgical procedures. Medicare currently pays 78 percent more in OPDs than in ASCs for the same procedure, and this payment gap has increased over time, influencing some ASC owners to sell their facilities to hospitals. 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 average patient severity that is no greater in OPDs than in ASCs. This policy would reduce Medicare program spending and beneficiary cost sharing by about \$590 million per year. Cost-sharing savings would range from \$40 million to \$220 million, depending on how OPDS copayments are determined. On average, hospitals' overall Medicare revenue would decline by 0.4 percent, and OPD revenue would fall by 1.7 percent.

We are concerned about the impact of the policies discussed in this chapter on hospitals that provide ambulatory physician services to a disproportionate share of low-income patients, who may be more likely than other patients to use an OPD as their usual source of care. Because large reductions in Medicare revenue for these hospitals could adversely affect access to physicians' services for these patients, we consider a stop-loss policy that would limit the loss of Medicare revenue for these hospitals. ■

How should Medicare pay for the same ambulatory services in different settings?

Medicare's payment rates often vary for the same ambulatory services provided to similar patients in different settings, such as physicians' offices, hospital outpatient departments (OPDs), and ambulatory surgical centers (ASCs). CMS 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. For services provided in OPDs or ASCs, Medicare makes two payments: one for the physician's professional fee under the PFS and one for the OPD or ASC facility fee under the OPPS or ASC payment system (see text box, p. 32).

As an example of payment differences, in 2013, Medicare pays 141 percent more in an OPD than in a freestanding physician's office for a level II echocardiogram (counting the professional fee and facility fee). In addition, in 2013, Medicare pays 70 percent more in an OPD than in a freestanding office for a 15-minute evaluation and management (E&M) office visit.¹ These types of variations raise questions about how Medicare should pay for the same service when it is delivered in different settings.

The Commission's position is that Medicare should ensure that patients have access to settings that provide the appropriate level of care. From this perspective, if the same service can be safely provided in different settings, a prudent purchaser should not pay more for that service in one setting than in another. However, these payment differences between settings may cause Medicare and beneficiaries to pay more than necessary and may encourage arrangements among providers that result in more care being provided in higher paid settings. Therefore, in its fee-for-service payment systems, Medicare should strive to base payment rates on the resources needed to treat patients in the most efficient (i.e., highest quality, lowest cost) setting, adjusting for differences in patient severity to the extent that severity differences affect costs. In the absence of comparable data on providers' costs and quality across settings, Medicare should base payment rates on the setting where beneficiaries have adequate access to care at the lowest

cost to the program and beneficiaries. Based on these principles, the Commission recommended in 2012 that Medicare reduce payment rates for E&M office visits provided in OPDs so that total payment rates would be equal whether these visits were provided in an OPD or in a freestanding physician's office (Medicare Payment Advisory Commission 2012c).

The goals of this chapter are to:

- move beyond E&M services and explore opportunities to align payment rates across settings for additional services that receive higher payments in OPDs than in other ambulatory settings;
- examine the impact of potential payment changes on Medicare spending, beneficiary cost sharing, and hospital revenue; and
- elicit feedback from the public on potential policy changes.

Although we explore options for reducing variations in payment rates across settings, we do not recommend payment changes in this chapter. We describe 66 groups of services provided in OPDs and physicians' offices that meet the Commission's principles for aligning payment rates across settings. Next we focus on a subset of the 66 groups: 3 groups of cardiac imaging services that have been migrating rapidly from freestanding offices to OPDs. Finally, we explore a policy that would equalize payment rates for certain ambulatory surgical procedures between OPDs and ASCs.

Some stakeholders have argued that Medicare should pay higher rates for all services provided in OPDs because the additional payments subsidize hospital standby capacity, access to care for low-income patients, efforts to improve care coordination, and community outreach. However, building indirect subsidies for these activities into the payment rates for all services does not directly target resources to these activities and can distort prices, which could have unintended consequences. For example, paying much more for cardiac tests in OPDs than in freestanding offices may encourage hospitals to purchase cardiology practices and shift cardiac testing to the OPD setting (see discussion, p. 33). In addition, paying higher rates for services provided in OPDs is an inefficient way to reward hospitals for improving care (such as reducing readmissions) because it does not distinguish between hospitals that improve care and reduce spending and those that do not. Although some of the hospitals

How Medicare pays for services in physicians' offices and hospital outpatient departments

Services covered under the fee schedule for physicians and other health professionals, also known as the physician fee schedule (PFS), have two payment rates: one for when the physician provides the service in his or her office (the nonfacility rate) and another for when the physician provides the service in a facility such as a hospital outpatient department (OPD), other provider-based entity, or ambulatory surgical center (the facility rate).² An outpatient facility that has provider-based status is considered part of a hospital, and provider-based status is available for hospital-owned entities that meet certain rules, such as being located on the hospital campus or off campus but within 35 miles of the hospital campus. In general, the nonfacility rate is higher than the facility rate in the PFS because physicians' practice costs are higher when physicians provide care in their offices instead of in facilities because they have to cover their direct costs (e.g., equipment, supplies, and staff) and have higher overhead costs.

When a service is provided in a physician's office, there is a single payment for the service. However, when a service is provided in a facility, Medicare makes a payment to the facility in addition to the payment to the physician. For example, if a 15-minute evaluation and management office visit for an established patient (Current Procedural Terminology code 99213) is provided in a freestanding physician's office, the program pays the physician 80 percent of the nonfacility payment rate from the PFS and the beneficiary is responsible for the remaining 20 percent. In 2013, the PFS nonfacility rate for this service is \$72.50; the program pays \$58.00 and the patient is responsible for \$14.50 (Table 2-1). 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 outpatient prospective payment system and the patient is responsible for 20 percent of both rates.³ The PFS facility rate in 2013 is \$49.70, and the OPPS payment is \$73.68, for a total payment of \$123.38. The program pays \$98.70 and the patient is responsible for \$24.68. ■

**TABLE
2-1**

Medicare and beneficiaries pay more for a 15-minute E&M office visit provided in an OPD than in a freestanding physician's office, 2013

	Service provided in freestanding physician practice*	Service provided in OPD		
		Physician facility rate*	OPPS rate	Total, OPD rate
Program payment	\$58.00	\$39.76	\$58.94	\$98.70
Beneficiary cost sharing	14.50	9.94	14.74	24.68
Total payment	72.50	49.70	73.68	123.38

Note: E&M (evaluation and management), OPD (hospital outpatient department), OPSS (outpatient prospective payment system). The Current Procedural Terminology code for this visit is 99213.

*Paid under the Medicare physician fee schedule.

Source: MedPAC analysis of payment rates in the 2013 physician fee schedule and OPSS.

that benefit from the higher rates that Medicare pays for services delivered in OPDs relative to freestanding offices have lower Medicare spending per episode of care, others have higher spending per episode (see text box, pp. 34–35). Medicare should directly reward those hospitals that improve care and reduce utilization.

With regard to hospital costs that are associated with community benefits but are hard to quantify, such as the

cost of standby capacity, these costs should be considered as part of the Commission's annual assessment of payment adequacy. Each year in our March report, we examine whether aggregate Medicare payments to hospitals are adequate to cover the costs efficient hospitals incur (Medicare Payment Advisory Commission 2013). We also consider beneficiaries' access to care, hospitals' access to capital, and changes in the quality of care.

**TABLE
2-2**

E&M office visits and cardiac imaging services migrated 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, 2010-2011	
		Freestanding office	OPD
E&M office visits (CPT codes 99201-99215)	9.7%	-0.2%	7.8%
Echocardiograms without contrast (APCs 269, 270, 697)	29.6	-6.3	17.6
Nuclear cardiology (APCs 377, 398)	33.0	-12.0	13.6

Note: E&M (evaluation and management), OPD (hospital outpatient department), CPT (Current Procedural Terminology), APC (ambulatory payment classification).

Source: MedPAC analysis of Standard Analytic Claims Files from 2010 and 2011.

Payment variations across settings urgently need to be addressed because many ambulatory services have been migrating from physicians' offices to the usually higher paid OPD setting, as hospital employment of physicians has increased. According to data from the American Hospital Association annual survey of hospitals, the number of physicians and dentists employed by hospitals was relatively constant from 1998 to 2003 but grew by 55 percent from 2003 to 2011.⁴ A survey conducted by the American College of Cardiologists found that the share of cardiologists who are employed by hospitals tripled between 2007 and 2012, from 11 percent to 35 percent (American College of Cardiology 2012). During that period, the proportion of cardiologists who work for physician-owned practices fell from 59 percent to 36 percent.⁵ In addition, in most of the 12 health care markets examined by the Center for Studying Health System Change, hospitals have increased the number of employed physicians over the last 3 years (Berenson et al. 2012).

Many factors have been cited for the trend toward greater physician employment by hospitals:

- Physicians face rising costs to operate a private practice, including new technology such as electronic health records and the administrative costs of dealing with separate insurers (O'Malley et al. 2011).
- Many physicians desire a different work-life balance and more lifestyle flexibility than has been typical in the past (Kocher and Sahni 2011).
- Hospitals often choose to employ physicians to ensure a stable stream of tests, admissions, and referrals

to specialists. They are also interested in acquiring physician practices to prepare for new payment models such as accountable care organizations, which are integrated systems that take responsibility for controlling spending and improving quality.

- Medicare and many private insurers pay higher rates for many services provided in OPDs relative to physicians' offices (Ginsburg 2011, Jain 2012, Kocher and Sahni 2011, O'Malley et al. 2011).

As more physicians become employed by hospitals, service billing is shifting from freestanding physicians' offices to OPDs. Among E&M office visits, echocardiograms, and nuclear cardiology, for example, the volume of services decreased in freestanding offices and increased in OPDs from 2010 to 2011 (Table 2-2).

Because most services receive higher payment rates when provided in OPDs than in freestanding offices, the migration of services to OPDs results in higher program spending and beneficiary cost sharing without significant changes in patient care. In many cases, a physician's practice that is purchased by a hospital stays in the same location and treats the same patients (Dutton 2012, Mathews 2012, Schulte 2012). Nevertheless, if the hospital converts a practice to an OPD and begins billing under the OPDS, Medicare and beneficiaries pay more for the same services. The growth in hospital employment of physicians and the associated increase in payment rates also affect private plans and their enrollees (see text box, p. 36).

From 2010 to 2011, the share of E&M office visits provided in the OPDs of OPDS hospitals increased by 9 percent. If this annual rate of increase continues from 2011

The relationship between higher hospital outpatient department payment rates and Medicare spending per episode is weak

Some stakeholders claim that when services are provided in hospital outpatient departments (OPDs) instead of in freestanding offices, care is better integrated and coordinated, lowering spending per episode of care. According to this argument, the higher rates that Medicare pays for services delivered in OPDs relative to freestanding offices are more than offset by the savings from fewer services delivered during an episode. An alternative hypothesis is that the higher payment rates for OPDs are associated with higher spending per episode. To examine this issue, we analyzed the relationship between hospitals' Medicare spending per episode and the share of hospitals' Medicare revenue that comes from higher OPD payment rates for evaluation and management (E&M) office visits and the services in 66 ambulatory payment classification (APC) groups (these 66 APCs are discussed on pp. 37–40). We found a weak negative correlation between the share of revenue hospitals gain from higher OPD rates and 30-day episode spending (Figure 2-1).

Each hospital in Figure 2-1 is represented as a distinct data point. The horizontal axis in Figure 2-1 displays each hospital's 30-day episode spending relative to the median hospital. We obtained this information from CMS's Medicare Spending Per Beneficiary (MSPB) measure, which evaluates hospitals' efficiency relative to the efficiency of the median hospital (Centers for Medicare & Medicaid Services 2012). The MSPB measure is based on Medicare payments for services performed by hospitals and other providers during an episode, which comprises the period immediately before, during, and 30 days after a patient's hospital stay. Hospitals with a score greater than one are less efficient than average and hospitals with a score less than one are more efficient than average. The vertical axis in Figure

2-1 displays the share of hospitals' overall Medicare revenue that comes from the difference between payment rates for E&M office visits and 66 APCs in OPDs and freestanding offices.

If hospitals that benefit more from higher OPD payments for these services had lower spending per episode, the data points would cluster tightly around a downward-sloping line, indicating that a large share of the variation in episode spending is explained by the share of hospitals' Medicare revenue that comes from the higher payment rates for services delivered in OPDs relative to freestanding offices. Conversely, if hospitals that benefit more from higher OPD payments had higher spending per episode, the data points would cluster tightly around an upward-sloping line. However, the data points are largely random. We performed a regression that used relative spending per episode as the dependent variable and the share of hospitals' Medicare revenue that comes from the difference between payment rates for E&M visits and 66 APCs in OPDs and freestanding offices as the explanatory variable. This regression produced a coefficient on the explanatory variable that was statistically significant but small: A 1 percentage point increase in a hospital's share of overall Medicare revenue that comes from higher payment rates for these services results in a decline in the MSPB efficiency measure of 0.01 (a decline in MSPB indicates an improvement in efficiency). In addition, this regression had an R^2 (a measure of statistical correlation) of 0.05, indicating a weak relationship between higher OPD payments and spending per episode. One factor that could explain why the relationship is weak is that the MSPB measure is primarily composed of spending for inpatient and post-acute care services rather than ambulatory care services. In summary, it appears that hospitals that receive a relatively high share of revenue from the higher

(continued next page)

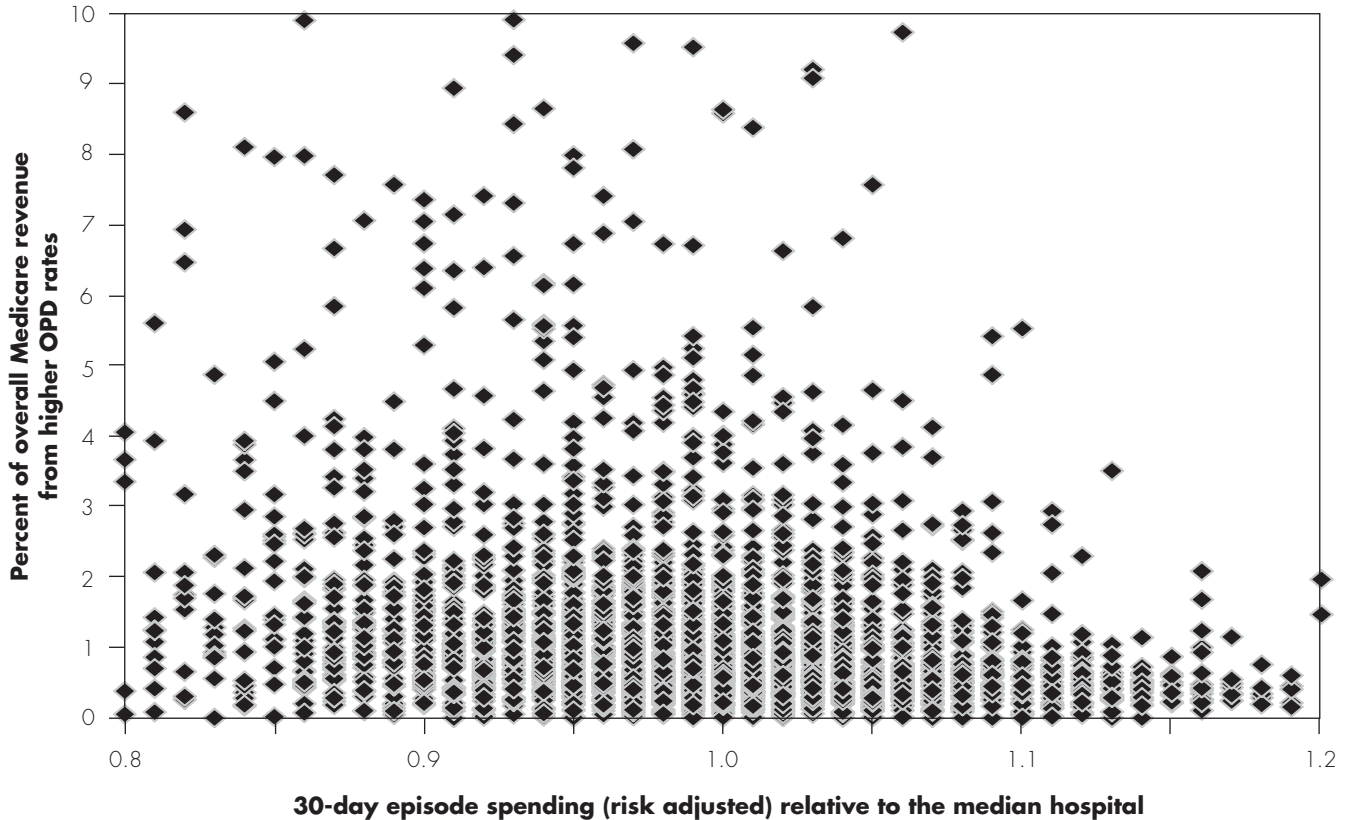
to 2021, 20 percent of E&M visits would be provided in OPDs in 2021. Such a shift would increase Medicare spending by \$1.2 billion per year and beneficiary cost sharing by \$300 million per year (assuming 2013 payment rates). From 2010 to 2011, the share of echocardiograms provided in OPDs increased by about 15 percent, and

the share of nuclear cardiology tests provided in OPDs increased by about 22 percent.⁶ If these annual rates of increase continue from 2011 to 2021, virtually all of these services in ambulatory settings would be provided in OPDs.⁷ Assuming 2013 payment rates for the OPDS and PFS, this shift would increase Medicare spending by

The relationship between higher hospital outpatient department payment rates and Medicare spending per episode is weak (cont.)

FIGURE 2-1

Weak correlation between revenue gains from higher OPD rates and 30-day episode spending



Note: OPD (hospital outpatient department). Each hospital is represented as a distinct data point. The horizontal axis displays hospitals' risk-adjusted Medicare spending for a 30-day episode relative to the median hospital. This information is from CMS's Medicare Spending Per Beneficiary Measure (MSPB), which evaluates hospitals' efficiency relative to the efficiency of the median hospital. The vertical axis displays the percent of hospitals' overall Medicare revenue that comes from the difference between OPD and physician office payment rates for services in Group 1 and Group 2 and evaluation and management office visits. See online-only Appendix 2-A, available at <http://www.medpac.gov>, for a list of services in Group 1 and Group 2.

Source: MedPAC analysis of 100 percent Standard Analytic Claims Files from 2010 and CMS's MSPB for 2011

rates for certain OPD services are only marginally more efficient, on average. Even if these hospitals were substantially more efficient, however, paying higher rates for OPD services to all hospitals—whether or not they

are efficient—is not a good use of Medicare's limited funds. A better alternative would be to directly reward hospitals that achieve lower spending per beneficiary for an episode of care. ■

\$1.1 billion per year and beneficiary cost sharing by \$290 million per year.

One way to address payment variations between physicians' offices and OPDs is to set payment rates so that they are equal whether a service is provided in a

freestanding physician's office or in an OPD. There are precedents for this approach: Medicare pays the same amount for outpatient therapy services, mammography tests, dialysis services, and clinical lab tests regardless of setting. However, important differences between

Growth of hospital employment of physicians leads to higher spending by private plans and their enrollees

The growth of hospital employment of physicians is leading to higher spending by private plans outside of Medicare and higher cost sharing for their enrollees (Alexander et al. 2012, Dutton 2012, Kowalczyk 2013a, Kowalczyk 2013b, Mathews 2012). In one example, 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 (Mathews

2012). The patient's share of the bill was about \$1,000. 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 (Kowalczyk 2013a). In some cases, private plans have stopped paying the additional facility fee for routine office visits provided in hospital-owned entities (Kowalczyk 2013a, Ostrom 2012). ■

physicians' offices and OPDs can lead to higher costs in OPDs for certain services:

- Hospitals incur costs to maintain standby capacity for handling emergencies. They are subject to the Emergency Medical Treatment and Active Labor Act of 1986 (EMTALA), which requires them to screen and stabilize (or transfer) patients who believe they are experiencing a medical emergency, regardless of their ability to pay.⁸
- Patients who receive a given service in an OPD may be more medically complex than patients who receive the same type of service in a freestanding office; it may require more time and resources to treat these patients.
- Hospitals face a unique set of licensing and accreditation requirements that increase their cost structure. Hospitals are required to meet conditions of participation in the Medicare program, which add to their costs; these conditions do not apply to freestanding physicians' offices. Hospitals also must comply with more stringent building codes and life-safety codes. In addition, an outpatient facility that is considered part of a hospital must meet CMS's rules for provider-based status, such as maintaining financial integration with the parent hospital. When a hospital purchases a freestanding office and converts it to an OPD to obtain higher payment rates, the hospital may need to make changes to the office to comply with these additional regulatory requirements. These changes could increase the costs incurred by

the provider, Medicare, and beneficiaries without evidence that patient care has improved.

- The OPDS is more likely than the PFS to combine the cost of primary services with ancillary services and supplies into a single payment (this concept is called packaging); the PFS tends to pay separately for each item. Therefore, some portion of the higher OPDS payment rates for many services reflects a greater level of packaging.

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

For our March 2012 report, we focused on E&M office visits, which are similar across settings (Medicare Payment Advisory Commission 2012c). These services are indicated by Current Procedure Terminology (CPT) codes 99201 through 99215 and are included in ambulatory payment classification (APC) groups 604 through 608. For these services, it is reasonable to equalize payment rates in physicians' offices and OPDs because:

- Hospitals do not need to maintain standby capacity for E&M visits that are not provided in an emergency department (ED), nor do the EMTALA requirements to screen and stabilize patients presenting at EDs affect the costs of furnishing E&M visits in OPDs.
- To a large extent, differences in resource needs because of patient complexity for these visits are

reflected in their coding structure, which classifies visits based on their length and complexity.⁹

- The extent to which ancillary items are packaged with E&M services is similar across the PFS and OPDS. On the basis of our analysis of 10,000 OPD claims that included an E&M visit, the cost of ancillary services that were packaged with these visits when provided in an OPD was about 2.5 percent of the visits' total cost. In other words, ancillaries 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 (Medicare Payment Advisory Commission 2012c). To equalize the total rates, the OPDS payment for an E&M visit would be reduced so that it equals the difference between the nonfacility practice expense (PE) amount and the facility PE amount in the PFS (see online-only Appendix 2-B, available at <http://www.medpac.gov>).

We estimated that this recommendation would reduce hospitals' overall Medicare revenue by 0.6 percent and outpatient revenue by 2.8 percent, but the effect would vary widely by type of hospital. For example, major teaching hospitals would have the largest loss of overall Medicare revenue (1.1 percent) and for-profit hospitals would have the smallest loss (0.2 percent) (Medicare Payment Advisory Commission 2012c). To allow time for hospitals to adjust to the lower rates for E&M visits, we recommended that this policy be phased in over three years.

In developing this recommendation, we were concerned that some hospitals that provide access to ambulatory physician services for low-income patients might experience significant reductions in Medicare revenue, which could potentially reduce access for these patients. Therefore, during the three-year phase in, we recommended that revenue losses from this policy be limited to 2 percent of overall Medicare revenue for hospitals that serve a relatively large share of low-income patients, defined as having a disproportionate share (DSH) percentage that is at or above the median for all hospitals (about 25.6 percent in 2010).¹⁰ In addition, we recommended that the Secretary study whether equalizing payment rates for E&M visits would impair access for low-income patients to ambulatory physician services. If the Secretary finds access problems, targeted actions should be undertaken to protect access.

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

We have identified services beyond E&M office visits that meet the Commission's principles for aligning payment rates between OPDs and freestanding offices. We classify these services into two categories:

- **Group 1** includes services for which payment rates could be equal across settings, and
- **Group 2** includes services for which the OPD rate could be higher than the physician office rate but the difference could be reduced from the current level (see online-only Appendix 2-A, available at <http://www.medpac.gov>, for the list of services in Group 1 and Group 2).¹¹

Like the Commission's recommendation to equalize payment rates for E&M office visits across settings, a policy of aligning payment rates between OPDs and freestanding offices for additional services would not apply to critical access hospitals (CAHs); hospitals in Maryland; and hospitals outside the 50 states, the District of Columbia, and Puerto Rico because these entities are not paid under the OPDS.

Group 1: Services for which OPD and physician office payment rates could be equal

Group 1 includes services that meet the following five criteria for equalizing payment rates between OPDs and freestanding offices (E&M visits also meet these criteria):

- are frequently performed in physicians' offices (more than 50 percent of the time), indicating that they are likely safe and appropriate to provide in a freestanding physician's office and the PFS payment rates for these services are sufficient to ensure access to care;
- have minimal packaging differences across payment systems (i.e., the payment rate includes a similar set of services);
- are infrequently provided with an ED visit when furnished in an OPD (such services are unlikely to have costs that are directly associated with operating an ED);
- have patient severity that is no greater in OPDs than in freestanding offices; and

- are not 90-day global surgical codes (CMS assumes that physicians' costs for these codes are higher when performed in a hospital than in a freestanding office).¹²

To identify services that meet these criteria, we grouped individual CPT codes into APCs because the OPSS uses APCs to classify services for payment.¹³ Each of the criteria must be met at the APC level rather than at the level of each CPT code that is included in an APC. For example, we apply the criterion that at least 50 percent of an APC's volume must have been performed in freestanding offices to the entire APC rather than to each CPT code within the APC.

We used 2010 claims data for the following analyses:

- For each APC, we determined the total volume of services provided in OPDs and freestanding offices. We then identified APCs for which at least 50 percent of the total volume occurred in freestanding offices.¹⁴
- We classified APCs as having minimal packaging if less than 5 percent of their OPD costs were related to packaged ancillaries, such as drugs and minor procedures. We used claims data from CMS to compute the total cost incurred by OPDs to furnish the services in each APC and the share of the total cost related to packaged ancillaries.
- For each APC, we determined how frequently services provided in OPDs were billed on the same claim or date of service as an ED visit. When an APC was provided with an ED visit less than 10 percent of the time, we assumed that the APC's total costs were minimally affected by the cost of operating an ED. The EMTALA requirement for hospitals to screen and stabilize patients who believe they are experiencing an emergency should have a very small impact on the cost of furnishing these APCs.
- For each APC, we calculated the share of volume related to services with 90-day global surgical codes. We excluded APCs from our analysis if 90-day global codes accounted for at least 5 percent of their total volume.
- For each APC, we examined differences in patient severity among patients treated in OPDs and freestanding offices. We used risk scores from the CMS–hierarchical condition categories (CMS–HCC) risk-adjustment model used in Medicare Advantage to measure patient severity. CMS–HCC risk scores

predict beneficiaries' relative costliness based on diagnoses from the prior year and demographic information. Beneficiaries who have higher risk scores are likely to be sicker and may require more time and resources to treat. We calculated the mean risk score for patients treated in OPDs and the mean risk score for patients treated in physicians' offices for each APC. If the mean OPD risk score was not statistically higher than the mean office risk score, we assumed that the severity of patients who received that group of services in OPDs was no greater than the severity of patients treated in offices.¹⁵

The limitation of using risk scores to estimate the relative cost of providing a specific service across settings is that the scores predict patients' relative costliness across the full range of health care services and do not necessarily indicate that a patient who has a high risk score will be more costly for a specific service. Despite these limitations, we used CMS–HCC risk scores as a proxy for patient severity because we do not have comparable cost data for OPDs and freestanding offices that would allow us to directly evaluate the impact of patient severity on the cost of providing individual services. In recent work, the Commission used CMS–HCC risk scores to examine variations in beneficiaries' health status across OPDs and ASCs (Medicare Payment Advisory Commission 2013).

We identified 24 APCs that met the 5 criteria for equal payment rates between OPDs and freestanding offices. The total payment for these APCs can be made equal across settings if we replace the existing OPSS payment rate with a rate that equals the difference between the nonfacility PE rate and the facility PE rate in the PFS (Table 2-3). We adjusted OPSS payment rates at the APC level rather than the CPT level. Most APCs have more than one CPT code, and all CPT codes in the same APC have the same payment rate under the OPSS. In contrast, the PFS has separate payment rates for each CPT code. When we adjusted the OPSS payment rate for an APC, we used a weighted average of the payment rates from the PFS for the CPT codes in that APC. For a more detailed discussion of our method of identifying services that met the criteria for Group 1 and Group 2, and our method of aligning payment rates between OPDs and freestanding offices for Group 1 and Group 2, see online-only Appendix 2-B, available at <http://www.medpac.gov>.

When a physician provides a service in a freestanding office or in an OPD, the physician's payment under the PFS has three components: physician work, PE, and

**TABLE
2-3**

Differences in payment rates for level II echocardiogram without contrast provided in physician's office and OPD, 2013

	Payment amount	Calculation
Current payment rates		
<i>Service in physician's office</i>		
Payment to physician	\$188.31	Work (\$) + PLI (\$) + nonfacility PE (\$)
<i>Service in OPD</i>		
Payment to physician	\$62.40	Work (\$) + PLI (\$) + facility PE (\$)
Payment to hospital	\$390.49	OPPS rate (\$)
Total payment	\$452.89	
Policy that aligns rates across settings		
<i>Service in OPD</i>		
Payment to physician	\$62.40	Work (\$) + PLI (\$) + facility PE (\$)
Payment to hospital	\$125.91	Nonfacility PE (\$) – facility PE (\$)
Total payment	\$188.31	

Note: OPD (hospital outpatient department), PLI (professional liability insurance), PE (practice expense), OPSS (outpatient prospective payment system). Payments include both program spending and beneficiary cost sharing. The services in this table are in ambulatory payment classification (APC) 269. When the services in this APC are provided in a physician's office, the average payment amount for physician work is \$44.31, the PLI amount is \$1.72, and the nonfacility PE amount is \$142.28. When the services in this APC are provided in an OPD, the average payment amount for physician work is \$44.31, the PLI amount is \$1.72, and the facility PE amount is \$16.37.

Source: MedPAC analysis of physician fee schedule and OPSS payment rates for 2013.

professional liability insurance (PLI). The work and PLI payments are the same regardless of setting. However, the PE payment for a service provided in a freestanding office (the nonfacility PE) is usually higher than the PE payment for a service provided in an OPD (the facility PE). The higher nonfacility PE payment reflects the cost of the clinical staff, medical equipment, medical supplies, and additional overhead incurred by the physician. Therefore, the PFS payment is higher in a freestanding office than in an OPD for most services. However, when a service is provided in an OPD, Medicare makes an additional payment to the hospital under the OPSS. In most cases, the PFS payment for a service that is provided in a freestanding office is lower than the combined OPD and PFS payments for a service delivered in an OPD.

For example, when a level II echocardiogram without contrast is provided in a freestanding office, the payment to the physician equals physician work plus PLI plus nonfacility PE, which totals \$188.31 in 2013 (Table 2-3). If the service is provided in an OPD, the total payment equals the sum of the work, PLI, facility PE, and OPSS payment for a total of \$452.89. However, if the OPSS rate is set equal to the difference between the nonfacility PE rate and the facility PE rate, the OPSS rate would drop to \$125.91 and the total payment would fall to \$188.31, which is the same rate that is paid in a freestanding office.

Most of the APCs that met the criteria for Group 1 were diagnostic tests, such as:

- level II echocardiogram without contrast (APC 269),
- level II extended electroencephalography (EEG), sleep, and cardiovascular studies (APC 209),
- bone density: axial skeleton (APC 288), and
- level II neuropsychological testing (APC 382).

Some procedural APCs also met the criteria, such as level II eye tests and treatments (APC 698). An example of a service in APC 698 is extended visual field exams such as Goldman visual fields, CPT code 92083.

Group 2: Services for which the gap in payment rates between OPDs and physicians' offices could be reduced

Group 2 includes 42 APCs that have a significantly higher level of packaging in the OPSS than in the PFS (the cost of packaged ancillaries was more than 5 percent of their total OPD cost) but met the other 4 criteria for equal payment rates between OPDs and freestanding offices. Medicare could allow the OPD payment rate for these services to exceed the freestanding office rate by an amount equal to the cost of the additional packaging in the OPSS.¹⁶ An

**TABLE
2-4**

Differences in payment rates for level III echocardiogram without contrast provided in physician's office and OPD, 2013

	Payment amount	Calculation
Current payment rates		
<i>Service in physician's office</i>		
Payment to physician	\$278.61	Work (\$) + PLI (\$) + nonfacility PE (\$)
<i>Service in OPD</i>		
Payment to physician	\$94.82	Work (\$) + PLI (\$) + facility PE (\$)
Payment to hospital	\$558.66	OPPS rate (\$)
Total payment	\$653.48	
Policy that aligns rates across settings and adjusts for packaging		
<i>Service in OPD</i>		
Payment to physician	\$94.82	Work (\$) + PLI (\$) + facility PE (\$)
Payment to hospital for primary service	\$183.79	Nonfacility PE (\$) – facility PE (\$)
Payment to hospital for packaged services	\$166.15	
Total payment	\$444.76	

Note: OPD (hospital outpatient department), PLI (professional liability insurance), PE (practice expense), OPSS (outpatient prospective payment system). Payments include both program spending and beneficiary cost sharing. The services in this table are in ambulatory payment classification (APC) 270. When the services in this APC are provided in a physician's office, the average payment amount for physician work is \$68.95, the amount for PLI is \$3.16, and the nonfacility PE amount is \$206.49. When the services in this APC are provided in an OPD, the average payment amount for physician work is \$68.95, the amount for PLI is \$3.16, and the facility PE amount is \$22.70.

Source: MedPAC analysis of physician fee schedule and OPSS payment rates for 2013.

example of an APC in Group 2 is level III echocardiogram without contrast (APC 270), for which about 30 percent of its OPD costs are related to packaged ancillaries, such as pharmaceuticals, supplies, and related imaging services. We calculated a revised OPD payment rate for this APC as follows (Table 2-4). First, we computed a payment to the hospital for the primary service that equals the difference between the nonfacility PE rate and the facility PE rate in the PFS (\$183.79). Next, we added a payment to the hospital to cover the cost of services that are packaged under the OPSS (\$166.15). Finally, we added the physician payment (\$94.82). The total hospital payment would be \$444.76 (instead of the current payment of \$653.48).

APCs in Group 2 cover a broad spectrum, including:

- minor procedures such as level I debridement and destruction (APC 12),
- more advanced procedures such as small intestine endoscopy (APC 142),
- advanced imaging such as cardiac computed tomographic imaging (APC 383), and
- tests such as level IV pathology (APC 344).

Effects of equalizing or limiting differences in payment rates between physicians' offices and OPDs

For APCs in Group 1, we estimated OPSS payment rates that would result in equal total payment rates in offices and OPDs. For APCs in Group 2, we estimated OPSS payment rates that account for the cost of additional packaged services in the OPSS but would otherwise produce equal payments across settings. We modeled the effect of these changes on program spending and beneficiary cost sharing for each of the 66 APCs in Group 1 and Group 2. For some APCs, the spending and cost sharing would decline substantially; for others the decline would be small; and for a few it would increase (when the OPD rate is currently below the physician office rate) (Table 2-5). Changing OPSS payment rates for APCs in Group 1 and Group 2 would, on net, reduce program spending and beneficiary cost sharing by a total of \$900 million in one year.

Impact on beneficiary cost sharing

Beneficiary cost-sharing savings would range from \$140 million to \$380 million, depending on how OPSS copayments are determined. When CMS adopted the OPSS, beneficiary copayments for many OPD services

**TABLE
2-5**

Ten APCs with the largest reduction in program spending and beneficiary cost sharing and 10 APCs with the largest increase in spending and cost sharing due to reducing differences in payment rates across settings, 2012

APC	APC description	Change in program spending and cost sharing	
		Total program spending (in millions)	Cost sharing (in millions)
10 APCs with largest reduction			
269	Level II echocardiogram without contrast	-\$308.5	-\$61.7
207	Level III nerve injections	-170.3	-34.1
377	Level II cardiac imaging	-168.5	-33.7
209	Level II extended EEG, sleep, and cardiovascular studies	-55.5	0.0
204	Level I nerve injections	-46.7	0.0
15	Level III debridement and destruction	-45.9	-9.2
440	Level V drug administration	-31.1	-6.2
20	Level II excision/biopsy	-30.0	-6.0
74	Level IV endoscopy upper airway	-28.1	0.0
160	Level I cystourethroscopy and other genitourinary procedures	-25.6	-5.1
10 APCs with largest increase			
126	Level I urinary and anal procedures	0.6	0.0
692	Level III electronic analysis of devices	0.6	0.1
678	External counterpulsation	0.7	0.1
1	Level I photochemotherapy	0.8	0.2
383	Cardiac computed tomographic imaging	0.9	0.2
300	Level I radiation therapy	2.0	0.4
288	Bone density: axial skeleton	6.1	0.0
96	Level II noninvasive physiologic studies	9.3	0.0
344	Level IV pathology	39.1	0.0
412	IMRT treatment delivery	159.6	31.9

Note: APC (ambulatory payment classification), EEG (electroencephalography), IMRT (intensity-modulated radiation therapy). We modeled cost-sharing changes based on current law: Copayments for APCs that are currently higher than 20 percent of the total payment rate would stay the same even if the total payment rate declines. APCs with copayments that equal 20 percent of the total payment rate would stay at 20 percent, but the copayment amount would be smaller if the total payment rate declines.

Source: MedPAC analysis of 100 percent Standard Analytic Claims files from 2010. MedPAC analysis of payment rates in the 2010 physician fee schedule and outpatient prospective payment system (OPPS) trended forward to 2012 using updates to the physician fee schedule and OPPS.

exceeded 20 percent of the total payment amount. The statute mandated that copayments would be frozen over time until they equaled 20 percent of the payment rate for all services. Currently, some of the APCs in Group 1 and Group 2, such as APC 269 (level II echocardiogram without contrast), have copayments that have reached the 20 percent level. However, other APCs, such as APC 209 (level II extended EEG, sleep, and cardiovascular studies), have copayments that continue to exceed 20 percent of the total payment amount.

One option is to set the copayment based on current law. Copayments for APCs above the 20 percent threshold would stay the same even when total payment rates change. For example, APC 209 has a copayment of \$269 in 2013, which is 33 percent of the total payment rate. The

copayment for this APC would remain \$269, even when the total payment rate declines. APCs with copayments that have reached the 20 percent level would stay at 20 percent, but the copayment amount would be smaller if the total payment rate declines. For example, APC 269 has a copayment of \$78 in 2013, which is 20 percent of the payment rate. To equalize payment rates across settings for this APC, the OPPS rate would decline from \$390 to \$126 and the copayment would decline to \$25 (20 percent of \$126) (Table 2-6, p. 42). This approach would maximize program savings; the Medicare program would save \$760 million and beneficiaries would save \$140 million in one year.

A second option is to keep the cost-sharing percentage constant for each APC after the total payment rate

**TABLE
2-6****Illustration of three options for setting OPPS copayment amounts
when payment rates are aligned for APC 269 and APC 209**

	APC 269	APC 209
Current OPPS payment rate	\$390	\$806
Current copayment	\$78	\$269
Copay as percent of payment rate	20%	33%
Adjusted payment rate	\$126	\$528
Options for setting the copayment		
(1) Under current law	\$25	\$269
(2) Copay percent is constant	\$25	\$176
(3) Copay is 20% of payment rate	\$25	\$106

Note: OPPS (outpatient prospective payment system), APC (ambulatory payment classification). APC 269 is level II echocardiogram without contrast; APC 209 is level II extended electroencephalography, sleep, and cardiovascular studies. Current law requires that copayments stay at their current level if they are more than 20 percent of the payment rate. If copayments equal 20 percent of the payment rate, then they stay at 20 percent when the payment rate changes.

Source: MedPAC analysis of 2013 payment rates for APCs 269 and 209 under the OPSS.

**TABLE
2-7****Reduction in overall Medicare revenue from aligning payment rates across settings
for selected ambulatory services (APCs in Groups 1 and 2 and E&M visits)**

	Percent loss of overall Medicare revenue			
	Group 1 and Group 2		Group 1 and Group 2, with E&M visits	
	Without stop-loss	With stop-loss	Without stop-loss	With stop-loss
All hospitals	0.6%	0.6%	1.2%	1.0%
Percent loss in revenue at:				
10th percentile	0.1	0.1	0.2	0.2
90th percentile	1.7	1.7	2.8	2.0
Urban	0.5	0.5	1.1	0.9
Rural	0.9	0.9	1.7	1.6
Nonprofit	0.6	0.6	1.1	1.0
For profit	0.5	0.5	0.8	0.7
Government	0.6	0.6	1.6	1.2
Major teaching	0.5	0.5	1.7	1.3
Other teaching	0.5	0.5	0.9	0.9
Nonteaching	0.6	0.6	1.1	1.0
DSH percentage				
Below median	0.6	0.6	1.2	1.2
Above median	0.5	0.5	1.2	0.9
Number of beds				
Less than 50	1.5	1.4	2.2	2.0
50-100	1.1	1.1	1.8	1.7
101-250	0.6	0.6	1.2	1.1
251-500	0.5	0.5	1.0	0.8
More than 500	0.4	0.4	1.1	0.9

Note: APC (ambulatory payment classification), E&M (evaluation and management), DSH (disproportionate share). The APCs in Group 1 and Group 2 are listed in online-only Appendix 2-A, available at <http://www.medpac.gov>.

Source: MedPAC analysis of 100 percent Standard Analytic Claims File from 2010 and hospital cost reports from 2010.

**TABLE
2-8**

Reduction in Medicare outpatient revenue from aligning payment rates across settings for selected ambulatory services (APCs in Groups 1 and 2 and E&M visits)

	Percent loss of Medicare outpatient revenue			
	Group 1 and Group 2		Group 1 and Group 2, with E&M visits	
	Without stop-loss	With stop-loss	Without stop-loss	With stop-loss
All hospitals	2.7%	2.6%	5.4%	4.8%
Percent loss in revenue at:				
10th percentile	0.8	0.8	1.3	1.3
90th percentile	5.8	5.7	10.1	8.5
Urban	2.5	2.5	5.3	4.6
Rural	3.4	3.4	6.2	5.7
Nonprofit	2.6	2.6	5.4	4.9
For profit	2.7	2.7	3.7	3.6
Government	2.9	2.9	7.2	5.5
Major teaching	2.9	2.8	8.9	6.9
Other teaching	2.4	2.4	4.6	4.2
Nonteaching	2.8	2.7	4.6	4.2
DSH percentage				
Below median	2.7	2.7	5.0	5.0
Above median	2.6	2.6	5.9	4.6
Number of beds				
Less than 50	4.6	4.4	6.9	6.1
50-100	3.8	3.7	6.6	6.0
101-250	2.8	2.8	5.2	4.8
251-500	2.2	2.2	4.7	4.1
More than 500	2.4	2.4	6.2	5.1

Note: APC (ambulatory payment classification), E&M (evaluation and management), DSH (disproportionate share). The APCs in Group 1 and Group 2 are listed in online-only Appendix 2-A, available at <http://www.medpac.gov>.

Source: MedPAC analysis of 100 percent Standard Analytic Claims File from 2010 and hospital cost reports from 2010.

changes. For example, the copayment for APC 209 is \$269 (33 percent of the payment rate). To equalize payment rates across settings for this APC, the OPPS rate would decline from \$806 to \$528. To maintain the copayment's current percentage of the payment rate, it would decrease to \$176. Under this approach, the Medicare program would save \$710 million and beneficiaries would save \$190 million.

A third option is to adjust the copayments in each APC so that they are 20 percent of the payment rate after the payment rate changes. This approach would maximize beneficiary savings; the Medicare program would save \$520 million and beneficiaries would save \$380 million.

Impact on hospitals' Medicare revenue

For all OPPS hospitals (excluding CAHs), changing the payment rates for the 66 APCs in Group 1 and Group 2

would reduce their overall Medicare revenue—which includes hospitals' Medicare revenue for all service lines (e.g., inpatient, outpatient, post-acute care)—by 0.6 percent and Medicare OPD revenue by 2.7 percent (Table 2-7 and Table 2-8). These revenue decreases would cause the overall Medicare and hospital outpatient margins to decrease. The effect of this policy would vary widely among hospitals. Ten percent of hospitals would lose 0.1 percent or less of overall Medicare revenue, and 10 percent would lose at least 1.7 percent of Medicare revenue (Table 2-7). The impact would differ for rural and urban hospitals: Rural hospitals would lose 0.9 percent of aggregate Medicare revenue, while urban hospitals would lose 0.5 percent. Rural hospitals would lose more revenue than urban hospitals because rural hospitals receive a larger share of their overall Medicare revenue from outpatient care than do urban hospitals (28 percent vs. 20 percent). Hospitals that receive a large share of their

**TABLE
2-9****Hospitals with largest reduction in overall Medicare revenue from aligning payment rates across settings for APCs in Group 1 and Group 2**

Variable	100 hospitals with largest reduction in Medicare revenue	All other hospitals
Average loss (overall Medicare revenue)	4.1%	0.5%
Median DSH percentage among hospitals in category	14.0	25.8
Percent:		
Major teaching	4.0	8.2
Rural	29.0	28.9
Nonprofit	41.0	59.8
For profit	57.0	23.1
Government	2.0	17.0
Average number of beds	44	198
Number of specialty hospitals	53	N/A

Note: APC (ambulatory payment classification), DSH (disproportionate share), N/A (not available). The “All other hospitals” category includes all the hospitals subject to the inpatient prospective payment system minus those in the “100 hospitals with largest reduction in Medicare revenue” category. For the “All other hospitals” category, we were unable to calculate the number of specialty hospitals. The APCs in Group 1 and Group 2 are listed in Appendix 2-A, available at <http://www.medpac.gov>.

Source: MedPAC analysis of 100 percent Standard Analytic Claims File from 2010 and hospital cost reports from 2010.

overall Medicare revenue through outpatient care would be disproportionately affected by policies that reduce OPSS payment rates. The revenue impact varies little by hospital ownership or teaching status. Hospitals with a DSH percentage below the median would have a similar revenue loss as hospitals with a DSH percentage above the median. There is an inverse relationship between revenue loss and hospital size as measured by number of beds. On average, relatively small hospitals would lose a higher percentage of their revenue than larger hospitals. This difference reflects in part the fact that smaller hospitals provide a higher share of outpatient care. We were not able to estimate the impact of this policy on hospitals with and without off-campus OPDs because there is no data source that indicates whether an OPD is located on or off campus.

We also examined the characteristics of the 100 hospitals (about 3 percent of all hospitals) that would have the largest percent reductions in overall Medicare revenue from changing OPSS payment rates for APCs in Group 1 and Group 2 (Table 2-9). We found the following differences between the 100 hospitals that would be most affected and all other hospitals:

- On average, the 100 most affected hospitals are smaller than other hospitals. They have an average of 44 beds, while the average among all other hospitals is 198 beds.

- The 100 most affected hospitals are less likely to serve low-income patients—the median DSH percentage is 14.0 percent for these hospitals versus 25.8 percent among all other hospitals.
- The 100 most affected hospitals are less likely to have major teaching status than all other hospitals.
- Over half of the 100 most affected hospitals are specialty hospitals.

The high proportion of specialty hospitals helps explain why the 100 most affected hospitals, on average, have fewer beds and a smaller share of Medicare outpatient revenue from ED visits. Specialty hospitals tend to have relatively few beds and are less likely to have EDs than other hospitals (Medicare Payment Advisory Commission 2005). In addition, 43 of the 100 most affected hospitals are specialty hospitals that focus on orthopedic or surgical cases. Orthopedic and surgical hospitals tend to concentrate on outpatient services (Medicare Payment Advisory Commission 2006).

We also estimated the combined effect on hospital-level Medicare revenue of adjusting OPSS payment rates for APCs in Group 1 and Group 2 and equalizing payment rates for E&M office visits between settings. For all OPSS hospitals, overall Medicare revenue would decline by 1.2 percent, and OPD revenue would decline by 5.4 percent

(Table 2-7, p. 42, and Table 2-8, p. 43). These combined policies would reduce program spending and beneficiary cost sharing by about \$1.8 billion per year. Depending on how cost-sharing changes would be implemented, these policies would save beneficiaries between \$330 million and \$570 million per year.

The effect of these policies would vary widely among hospitals. Ten percent of hospitals would lose 0.2 percent of overall Medicare revenue or less, and 10 percent would lose at least 2.8 percent (Table 2-7, p. 42). The impact of these policies would differ by type of hospital. Rural hospitals would lose 1.7 percent of their overall Medicare revenue, while urban hospitals would lose 1.1 percent. Government-owned hospitals would lose more revenue than nonprofit or for-profit hospitals. Major teaching hospitals would lose more revenue than nonteaching hospitals (1.7 percent vs. 1.1 percent). There is little difference between the revenue loss for hospitals with a DSH percentage below the median and those with a DSH percentage above the median. As with the impact of changing OPPS payment rates for APCs in Group 1 and Group 2 alone, small hospitals, on average, would lose a larger percentage of their revenue than large hospitals. This difference reflects the fact that smaller hospitals provide a higher share of outpatient care.

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

Some hospitals that are a primary source of access to physician services for low-income patients might experience significant reductions in Medicare revenue as a result of the policies discussed in this chapter, which could potentially reduce access for these patients. Therefore, policymakers may wish to consider a stop-loss policy that would limit the loss of Medicare revenue for these hospitals. There are several issues to consider in designing such a policy.

First, what criteria should Medicare use in determining which hospitals should be eligible for a stop-loss policy? One option is to base eligibility on a hospital's DSH percentage, which is the sum of the percentage of Medicare inpatient days for patients who are eligible for Supplemental Security Income (SSI) and the percentage of total inpatient days for patients on Medicaid. When the Commission recommended that payment rates should be equal whether an E&M office visit is provided in an OPD or in a freestanding office, we recommended that a stop-loss policy should apply to hospitals with a DSH

percentage that is at or above the median for all hospitals (Medicare Payment Advisory Commission 2012c). However, the DSH percentage is based on inpatient days, and the policies discussed in this chapter would affect outpatient revenue but not inpatient revenue. In addition, the DSH percentage is partly based on the share of inpatient days for Medicaid patients, which may be unrelated to a hospital's share of low-income Medicare patients. If the primary purpose of a stop-loss policy is to protect access to ambulatory services for low-income Medicare patients, perhaps the policy should be linked to the proportion of Medicare patients treated in an OPD who receive SSI.

Second, where should the eligibility threshold be set for a stop-loss policy? For example, the policy could apply to hospitals whose share of low-income patients is at or above the median for all hospitals, at or above the top quartile, or at or above the top decile. The level of the threshold influences how many hospitals would be eligible for a stop-loss policy.

Third, how much Medicare revenue should a stop-loss policy protect? For example, should overall Medicare revenue losses for eligible hospitals be limited to 1 percent, 2 percent, or a higher amount? As the level of revenue protection increases, the amount of savings for the program and beneficiaries from the policies discussed in this chapter will decline.

Fourth, should the stop-loss policy be temporary or permanent? With regard to equalizing payment rates across settings for E&M office visits, the Commission recommended a temporary stop-loss policy that would last for three years. This three-year period would coincide with a three-year phase-in of lower OPPS payment rates for E&M services. It would also give the Secretary time to examine whether equalizing payment rates for E&M visits would impair access for low-income patients to ambulatory services and to develop targeted policies, if necessary, to protect access. Although a permanent stop-loss policy would provide long-term protection for hospitals that serve a high share of low-income patients, it would require CMS to annually determine which hospitals would be eligible for the policy and calculate the amount of money to be returned to each eligible hospital at the end of the year based on the stop-loss level. By contrast, a temporary policy would increase the amount of long-term savings for the program and beneficiaries and would give the Secretary time to develop targeted policies to protect access to care.

There is also a concern that reducing Medicare revenue to hospitals that provide outpatient services to a disproportionate share of beneficiaries who are frail and in poor health could adversely affect access to physician services for these patients. Because low-income beneficiaries are more likely to be in poor health, protecting access for low-income patients should also help ensure access for patients who are sicker. According to the Medicare Current Beneficiary Survey, dual-eligible beneficiaries, who have much lower incomes than other Medicare beneficiaries, are more likely to report poor health status: 18 percent of the dual-eligible population reports being in poor health compared with 7 percent of other beneficiaries (Medicare Payment Advisory Commission 2012a).¹⁷ In addition, dual-eligible beneficiaries have more chronic conditions and cognitive and functional limitations than other beneficiaries (Jacobson et al. 2012). For example, 58 percent of dual-eligible beneficiaries have a cognitive or mental impairment compared with 25 percent of other beneficiaries.

For the purpose of this chapter, we illustrate a stop-loss policy based on the Commission's recommended stop-loss policy associated with our 2012 recommendation to equalize payment rates across settings for E&M office visits (Medicare Payment Advisory Commission 2012c). In this illustration, revenue losses would be limited to 2 percent of overall Medicare revenue for hospitals with a DSH percentage at or above the median for all hospitals. This illustrative stop-loss policy would have a small effect on the overall Medicare and outpatient Medicare revenue changes that would result from adjusting OPSS payment rates for APCs in Group 1 and Group 2 (Table 2-7, p. 42, and Table 2-8, p. 43). This illustrative policy would reduce overall savings in one year by about \$10 million, and only 2 percent of hospitals would have their overall revenue losses capped. The effect would be small because many of the hospitals with the highest revenue losses under this policy are less likely to serve low-income patients.

When we apply the illustrative stop-loss policy to a combined policy of adjusting OPSS payment rates for APCs in Group 1 and Group 2 and equalizing payment rates for E&M office visits between settings, the impact of the stop-loss policy on Medicare revenue changes is much larger (Table 2-7, p. 42, and Table 2-8, p. 43). About 7 percent of hospitals would have their overall Medicare revenue losses capped at 2 percent, which would reduce aggregate savings from the combined policy by \$210 million each year. The types of hospitals that would benefit

the most from the stop-loss policy would be government-owned and major teaching hospitals (Table 2-7, p. 42).

Impact on rural hospitals and beneficiaries

Under the policies described in this chapter for aligning payment rates between settings, rural hospitals would lose more overall Medicare revenue than urban hospitals (e.g., see Table 2-7, p. 42). This impact raises the question of whether rural beneficiaries would have access problems. About 60 percent of rural hospitals are CAHs, which would not be affected by these policies. Nevertheless, if policymakers determine that a mitigation policy is needed to prevent access problems for rural beneficiaries, they should target such a policy to rural hospitals that are uniquely essential for maintaining access to care in a given community, rather than all rural hospitals. Such a mitigation policy should be consistent with three principles developed by the Commission for our June 2012 report to guide special payments to rural providers:

- Payments should be targeted to low-volume isolated providers—that is, providers that have low patient volume and are at a distance from other providers.
- The magnitude of the special rural payment should be empirically justified: Payments should increase to the extent that factors beyond the providers' control increase their costs.
- Rural payment adjustments should encourage cost control on the part of providers (Medicare Payment Advisory Commission 2012b).

Aligning payment rates between OPDs and physicians' offices for cardiac imaging services

Instead of aligning payment rates between OPDs and freestanding offices for all of the 66 APCs that meet the criteria for Group 1 or Group 2, an alternative policy would target only the 3 APCs in Group 1 or Group 2 that include cardiac imaging services (echocardiograms and nuclear cardiology). The rationale for focusing on cardiac imaging is that these services have been migrating from freestanding offices to OPDs, where the payment rates are substantially higher (Table 2-2, p. 33). An important factor driving this migration is the rapid growth in hospitals' employment of cardiologists (Burling 2012, Ostrom

2012). According to a survey conducted by the American College of Cardiology, the share of cardiologists who are employed by hospitals tripled between 2007 and 2012, from 11 percent to 35 percent (American College of Cardiology 2012). In Washington State, for example, the share of cardiologists employed by hospitals grew between 2007 and 2012 from 2 percent to 42 percent (Ostrom 2012).

The shift in volume toward OPDs is consistent with the financial incentives in Medicare's payment systems:

- The payment rate for a level II echocardiogram without contrast (APC 269) is 141 percent higher in OPDs than in physicians' offices.
- The payment rate for a level III echocardiogram without contrast (APC 270) is 47 percent higher in OPDs than in physicians' offices, even after adjusting for differences in packaging.
- The payment rate for level II cardiac imaging (APC 377) is 19 percent higher in OPDs than in physicians' offices, even after adjusting for differences in packaging.

We estimate that aligning payment rates between OPDs and freestanding offices for these three cardiac APCs (APCs 269, 270, and 377) would reduce program spending and beneficiary cost sharing by a total of \$500 million in one year.¹⁸ Like the policy of aligning payment rates for APCs in Group 1 and Group 2 between settings, there are three options for distributing savings between the program and beneficiaries. However, beneficiaries would save about \$100 million under each option. The reason there is so little difference among the options is that most of the savings comes from APCs that currently have copayments that are 20 percent of the OPPS payment rate. Of the three APCs in this analysis, only APC 270 has a copayment above the 20 percent threshold, and this APC represents only 5 percent of the total savings from this policy.

We estimated the effect on hospital-level Medicare revenue of adjusting OPSS payment rates for the three cardiac imaging APCs. For all OPSS hospitals (which excludes CAHs), overall Medicare revenue would decline by 0.3 percent, while OPD revenue would decline by 1.5 percent (Table 2-10, p. 48, and Table 2-11, p. 49). The impact of these policies varies little for most types of hospitals. One exception is rural hospitals, which

would lose 0.5 percent of their overall Medicare revenue, compared with 0.3 percent for urban hospitals. Another exception is smaller hospitals (as measured by number of beds), which would lose a larger share of revenue than larger hospitals because they tend to be more focused on outpatient services.

We also examined the characteristics of the 100 hospitals that would have the largest percentage reduction in overall Medicare revenue from reducing OPSS payment rates for cardiac imaging APCs (Table 2-12, p. 49). We found the following differences between the 100 most affected hospitals and all other hospitals:

- On average, the 100 most affected hospitals are smaller than all other hospitals—they have an average of 69 beds, whereas all other hospitals have an average of 197.
- The 100 most affected hospitals are less likely to serve low-income patients—the median DSH percentage is 21.6 percent for these hospitals versus 25.7 percent for all other hospitals.
- Compared with all other hospitals, a higher proportion of the 100 most affected hospitals are rural and nonprofit.
- Only 1 of the 100 most affected hospitals has major teaching status, compared with 8.3 percent for all other hospitals.
- Only 6 of the 100 most affected hospitals are specialty hospitals. This small number is not surprising because cardiac specialty hospitals—the type of specialty hospital most likely to be affected by changes to payment rates for cardiac imaging services—have a strong focus on inpatient services (Medicare Payment Advisory Commission 2006). They also get a relatively small share of their Medicare OPD revenue from the three cardiac imaging APCs.

We also estimated the effect on hospital-level Medicare revenue of reducing OPSS payment rates for the three cardiac imaging APCs and equalizing payment rates for E&M visits across settings. These combined policies would reduce program spending and beneficiary cost sharing by about \$1.4 billion per year. They would save beneficiaries almost \$300 million per year. The impact of these policies would differ by type of hospital (Table 2-10, p. 48, and Table 2-11, p. 49).

**TABLE
2-10**

Reduction in overall Medicare revenue from aligning payment rates across settings for selected ambulatory services (cardiac imaging APCs and E&M visits)

	Percent loss of overall Medicare revenue			
	Cardiac imaging		Cardiac imaging, with E&M visits	
	Without stop-loss	With stop-loss	Without stop-loss	With stop-loss
All hospitals	0.3%	0.3%	0.9%	0.8%
Percent loss in revenue at:				
10th percentile	0.0	0.0	0.1	0.1
90th percentile	0.9	0.9	1.9	1.9
Urban	0.3	0.3	0.9	0.8
Rural	0.5	0.5	1.3	1.2
Nonprofit	0.3	0.3	0.9	0.8
For profit	0.3	0.3	0.5	0.5
Government	0.3	0.3	1.3	1.0
Major teaching	0.3	0.3	1.4	1.1
Other teaching	0.3	0.3	0.7	0.7
Nonteaching	0.4	0.4	0.8	0.7
DSH percentage				
Below median	0.4	0.4	0.9	0.9
Above median	0.3	0.3	0.9	0.8
Number of beds				
Less than 50	0.5	0.5	1.2	1.1
50–100	0.6	0.6	1.4	1.3
101–250	0.3	0.3	0.9	0.8
251–500	0.3	0.3	0.8	0.7
More than 500	0.3	0.3	1.0	0.8

Note: APC (ambulatory payment classification), E&M (evaluation and management), DSH (disproportionate share). The APCs included in cardiac imaging are 269, 270, and 377.

Source: MedPAC analysis of 100 percent Standard Analytic Claims File from 2010 and hospital cost reports from 2010.

Equalizing payment rates between OPDs and ASCs for certain ambulatory procedures

An alternative to aligning payment rates between OPDs and freestanding offices for the APCs in Group 1 and Group 2 would be to equalize payment rates for certain ambulatory surgical procedures between OPDs and ASCs. The relative weights for most procedures in the ASC payment system are based on the relative weights in the OPDS, but the ASC system uses a lower conversion factor (average payment amount).¹⁹ Therefore, payment rates for all procedures are much higher in the OPDS—for 2013, the Medicare rates for most services are 78 percent higher in OPDs than in ASCs. Beneficiary cost sharing is also much greater in OPDs than in ASCs. The gap in payment rates between the two settings has increased

over time, which has influenced some ASC owners to sell their facilities to hospitals and some health care systems to expand their OPDs rather than establish new ASCs (North Carolina Department of Health and Human Services 2008, State of Connecticut 2011). In addition, the migration of procedures from OPDs to ASCs from 2006 to 2010 appears to have stalled, perhaps because of higher payment rates in OPDs (Medicare Payment Advisory Commission 2013). From 2006 through 2010, the number of ASC-covered procedures per fee-for-service beneficiary grew by 5.8 percent per year in ASCs and by 0.1 percent per year in OPDs. In 2011, however, procedures increased at a slower rate in ASCs than in OPDs (1.8 percent vs. 3.8 percent). This change could signal the beginning of a movement of procedures from ASCs to OPDs.

We used the following three criteria to select services for which payment rates could be equalized between OPDs and ASCs:

**TABLE
2-11****Reduction in Medicare outpatient revenue from aligning payment rates across settings for selected ambulatory services (cardiac imaging APCs and E&M visits)**

	Percent loss of Medicare outpatient revenue			
	Cardiac imaging		Cardiac imaging, with E&M visits	
	Without stop-loss	With stop-loss	Without stop-loss	With stop-loss
All hospitals	1.5%	1.5%	4.3%	3.8%
Percent loss in revenue at:				
10th percentile	0.2	0.2	0.6	0.6
90th percentile	3.3	3.3	7.3	6.5
Urban	1.4	1.4	4.2	3.7
Rural	1.9	1.9	4.6	4.3
Nonprofit	1.5	1.5	4.3	4.0
For profit	1.3	1.3	2.3	2.3
Government	1.4	1.4	5.8	4.6
Major teaching	1.4	1.3	7.4	6.1
Other teaching	1.5	1.5	3.7	3.4
Nonteaching	1.5	1.5	3.3	3.1
DSH percentage				
Below median	1.5	1.5	3.8	3.8
Above median	1.4	1.4	4.7	3.8
Number of beds				
Less than 50	1.6	1.5	3.9	3.4
50-100	2.1	2.1	4.8	4.5
101-250	1.5	1.5	3.9	3.6
251-500	1.3	1.3	3.9	3.5
More than 500	1.4	1.4	5.2	4.5

Note: APC (ambulatory payment classification), E&M (evaluation and management), DSH (disproportionate share). The APCs included in cardiac imaging are 269, 270, and 377.

Source: MedPAC analysis of 100 percent Standard Analytic Claims File from 2010 and hospital cost reports from 2010.

**TABLE
2-12****Hospitals with largest reduction in overall Medicare revenue from aligning payment rates across settings for cardiac imaging APCs**

Variable	100 hospitals with largest reduction in Medicare revenue	All other hospitals
Average loss (overall Medicare revenue)	1.6%	0.3%
Median DSH percentage among hospitals in category	21.6	25.7
Percent:		
Major teaching	1.0	8.3
Rural	58.0	27.9
Nonprofit	67.0	59.0
For profit	18.0	24.4
Government	15.0	16.6
Average number of beds	69	197
Number of specialty hospitals	6	N/A

Note: APC (ambulatory payment classification), DSH (disproportionate share), N/A (not available). The "All other hospitals" category includes all the hospitals subject to the inpatient prospective payment system minus those in the "100 hospitals with largest reduction in Medicare revenue" category. For the "All other hospitals" category, we were unable to calculate the number of specialty hospitals. The APCs included in cardiac imaging are 269, 270, and 377.

Source: MedPAC analysis of 100 percent Standard Analytic Claims File from 2010 and hospital cost reports from 2010.

**TABLE
2-13**

Reduction in OPD payments from equalizing payment rates across settings for 12 APCs commonly performed in ASCs

APC	APC description	Reduction in payments (in millions)
137	Level V skin repair	\$26.5
203*	Level IV nerve injections	13.2
207*	Level III nerve injections	147.5
233	Level II anterior segment eye procedures	3.9
234	Level III anterior segment eye procedures	9.9
239*	Level II repair and plastic eye procedures	1.3
240	Level III repair and plastic eye procedures	16.4
241	Level IV repair and plastic eye procedures	5.2
244	Corneal and amniotic membrane transplant	9.5
245	Level I cataract procedures without IOL insertion	0.2
246	Cataract procedures with IOL insertion	341.2
247	Laser eye procedures	13.6
Total		588.4

Note: OPD (hospital outpatient department), APC (ambulatory payment classification), ASC (ambulatory surgical center), IOL (intraocular lens).
*These APCs also appear in Group 2. See online-only Appendix 2-A for the full list of APCs in Group 2, available at <http://www.medpac.gov>.

Source: MedPAC analysis of 100 percent Standard Analytic Claims File from 2010.

- services that are frequently performed in ASCs (more than 50 percent of the time), which indicates that they are likely safe and appropriate to provide in an ASC and the ASC payment amounts are sufficient to ensure beneficiaries' access;
- services that are infrequently provided with an ED visit when furnished in an OPD (such services are unlikely to have costs that are directly associated with operating an ED); and
- services for which patient severity is no greater in OPDs than in ASCs.

We also used these criteria to select services for which payment rates could be aligned between OPDs and freestanding offices (APCs in Group 1 and Group 2). However, we used two additional criteria to select services for Group 1 and Group 2 that do not apply to ASC services: the extent of packaging differences across payment systems and the presence of 90-day global surgical codes in an APC. Because the ASC payment system and the OPSS use the same rules for packaging ancillary services and supplies with a primary procedure, the unit of payment is the same in both settings. In addition, neither payment system uses 90-day global surgical codes. To select services for which payment rates

could be made equal in OPDs and ASCs, we measured the share of ambulatory surgical procedures performed in ASCs and the frequency with which OPD services are provided with an ED visit; we also examined patient severity differences between settings. We used the same method for these analyses that we used to identify APCs for Group 1 and Group 2 (see p. 38). This policy would not apply to CAHs because these entities are not paid under the OPSS.

We identified 12 APCs that met the three criteria for making payment rates equal between OPDs and ASCs (Table 2-13).²⁰ These APCs included nine eye procedure groups, two nerve injection groups, and one skin repair group. Three of these 12 APCs also appeared in Group 2 (none appeared in Group 1).²¹ If policymakers were to adopt the criteria for aligning payment rates between OPDs and physicians' offices along with the criteria for aligning payment rates between OPDs and ASCs, they would have to decide whether to use the physician's office or ASC payment rate as the basis for determining OPD rates for APCs that meet both sets of criteria. In these cases, the payment rate could be based on the ambulatory setting with the highest volume.

To equalize payment rates between OPDs and ASCs, we calculated a revised OPSS rate for each APC based on

**TABLE
2-14****Reduction in overall Medicare revenue from equalizing payment rates across settings for selected services (12 APCs commonly performed in ASCs and E&M visits)**

	Percent loss of overall Medicare revenue			
	12 APCs		12 APCs, with E&M visits	
	Without stop-loss	With stop-loss	Without stop-loss	With stop-loss
All hospitals	0.4%	0.4%	1.0%	0.9%
Percent loss in revenue at:				
10th percentile	0.0	0.0	0.1	0.1
90th percentile	1.4	1.4	2.7	2.0
Urban	0.3	0.3	0.9	0.8
Rural	0.7	0.6	1.4	1.3
Nonprofit	0.4	0.3	0.9	0.9
For profit	0.4	0.4	0.6	0.6
Government	0.4	0.4	1.4	1.1
Major teaching	0.3	0.3	1.4	1.2
Other teaching	0.3	0.3	0.7	0.7
Nonteaching	0.5	0.5	0.9	0.8
DSH percentage				
Below median	0.4	0.4	0.9	0.9
Above median	0.3	0.3	1.0	0.8
Number of beds				
Less than 50	1.6	1.5	2.4	2.1
50-100	0.7	0.7	1.5	1.4
101-250	0.4	0.4	0.9	0.9
251-500	0.3	0.3	0.8	0.7
More than 500	0.2	0.2	0.9	0.8

Note: APC (ambulatory payment classification), ASC (ambulatory surgical center), E&M (evaluation and management), DSH (disproportionate share). The 12 APCs are listed in Table 2-13.

Source: MedPAC analysis of 100 percent Standard Analytic Claims File from 2010 and hospital cost reports from 2010.

an average of the ASC rates for the CPT codes in that APC. For a more detailed discussion of our method, see Appendix 2-B, available online at <http://www.medpac.gov>. Our approach would not affect how OPDS relative weights are calculated; they would continue to be based on the median OPD cost of the services in each APC.

Effects of equalizing payment rates between OPDs and ASCs for selected services

We estimate that equalizing payment rates between OPDs and ASCs for these 12 APCs would reduce program spending and beneficiary cost sharing by a total of about \$590 million in one year. As with Group 1 and Group 2 of the prior analysis, there are three options for how to distribute savings among the program and beneficiaries. The amount of beneficiary savings varies widely among the options, ranging from \$40 million to \$220 million,

because 70 percent of the savings would come from APCs that currently have copayments above the 20 percent level, such as APC 207 (level III nerve injections) and APC 246 (cataract procedures with intraocular lens insertion).

Across all hospitals, equalizing payment rates between settings for these 12 APCs would reduce their overall Medicare revenue by 0.4 percent and OPD revenue by 1.7 percent (Table 2-14 and Table 2-15, p. 52). The effect of these policies would vary among some types of hospitals. Ten percent of hospitals would lose no overall Medicare revenue, but 10 percent would lose at least 1.4 percent of Medicare revenue (Table 2-14). Rural hospitals would lose 0.7 percent of their overall Medicare revenue, while urban hospitals would lose 0.3 percent. Nonteaching hospitals would have slightly larger losses than major teaching and other teaching hospitals. Hospitals that have DSH

**TABLE
2-15**

Reduction in Medicare outpatient revenue from equalizing payment rates across settings for selected services (12 APCs commonly performed in ASCs and E&M visits)

	Percent loss of Medicare outpatient revenue			
	12 APCs		12 APCs, with E&M visits	
	Without stop-loss	With stop-loss	Without stop-loss	With stop-loss
All hospitals	1.7%	1.7%	4.5%	4.0%
Percent loss in revenue at:				
10th percentile	0.0	0.0	0.3	0.3
90th percentile	5.1	5.1	9.5	8.2
Urban	1.6	1.6	4.4	3.9
Rural	2.4	2.3	5.1	4.7
Nonprofit	1.7	1.6	4.4	4.0
For profit	2.0	2.0	3.0	2.9
Government	1.8	1.8	6.1	4.8
Major teaching	1.7	1.6	7.7	6.3
Other teaching	1.4	1.4	3.6	3.3
Nonteaching	2.0	2.0	3.8	3.5
DSH percentage				
Below median	1.8	1.8	4.1	4.1
Above median	1.7	1.6	4.9	4.0
Number of beds				
Less than 50	5.1	4.6	7.3	6.4
50-100	2.5	2.4	5.2	4.8
101-250	1.8	1.8	4.2	3.9
251-500	1.4	1.4	3.9	3.5
More than 500	1.2	1.2	5.0	4.3

Note: APC (ambulatory payment classification), ASC (ambulatory surgical center), E&M (evaluation and management), DSH (disproportionate share). The 12 APCs are listed in Table 2-13.

Source: MedPAC analysis of 100 percent Standard Analytic Claims File from 2010 and hospital cost reports from 2010.

percentages below the median would have slightly larger losses than other hospitals, suggesting that there would be a slightly smaller effect on hospitals that serve low-income patients. Smaller hospitals (as measured by number of beds) would lose a larger share of revenue than larger hospitals in part because smaller hospitals tend to focus on outpatient care.

We also examined the characteristics of the 100 hospitals that would have the largest percentage reduction in overall Medicare revenue from equalizing payment rates between OPDs and ASCs for these 12 APCs (Table 2-16). We found the following differences between the 100 hospitals that would be most affected and all other hospitals:

- On average, the 100 most affected hospitals are much smaller than the average hospital—they have an

average of 32 beds, whereas the average among all other hospitals is 198.

- The 100 most affected hospitals are much less likely to serve low-income patients—the median DSH percentage is 10.7 percent for those hospitals versus 25.8 percent for all other hospitals.
- Compared with all other hospitals, a higher proportion of the 100 most affected hospitals are rural, but a smaller share are nonprofit or have major teaching status.
- Of the 100 most affected hospitals, 61 are specialty hospitals, and 53 of the specialty hospitals focus on orthopedics or surgery. Specialty hospitals tend to focus on outpatient care (except for cardiac hospitals), have very few beds and low DSH percentages, and are unlikely to be teaching hospitals.

**TABLE
2-16****Hospitals with largest reduction in overall Medicare revenue from equalizing payment rates between OPDs and ASCs for 12 APCs**

Variable	100 hospitals with largest reduction in Medicare revenue	All other hospitals
Average loss (overall Medicare revenue)	6.8%	0.3%
Median DSH percentage among hospitals in category	10.7	25.8
Percent:		
Major teaching	5.0	8.2
Rural	32.0	28.9
Nonprofit	33.0	60.1
For profit	59.0	23.1
Government	8.0	16.8
Average number of beds	32	198
Number of specialty hospitals	61	N/A

Note: OPD (hospital outpatient department), ASC (ambulatory surgical center), APC (ambulatory payment classification), DSH (disproportionate share), N/A (not available). The "All other hospitals" category includes all hospitals subject to the inpatient prospective payment system minus those in the "100 hospitals with largest reduction in Medicare revenue" category. For the "All other hospitals" category, we were unable to calculate the number of specialty hospitals. The 12 APCs are listed in Table 2-13.

Source: MedPAC analysis of 100 percent Standard Analytic Claims File from 2010 and hospital cost reports from 2010.

We also estimated the combined effect on hospital-level Medicare revenue of equalizing payment rates between OPDs and ASCs for 12 APCs and equalizing payment rates for E&M visits between OPDs and freestanding offices. These combined policies would reduce program spending and beneficiary cost sharing by about \$1.5 billion per year. They would save beneficiaries between \$230 million and \$410 million per year.

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

We illustrate the same stop-loss policy modeled earlier in the context of revising payment rates for APCs in Group 1 and Group 2: Revenue losses would be limited to 2 percent of overall Medicare revenue for hospitals with a DSH percentage at or above the median for all hospitals. This illustrative stop-loss policy would have very little impact on overall Medicare or outpatient Medicare revenue changes that result from equalizing rates between OPDs and ASCs for 12 APCs. The effect would be small because many of the hospitals with the highest revenue losses under this policy are much less likely to serve low-income patients.

However, when we apply the illustrative stop-loss policy to a combined policy of equalizing payment rates between OPDs and ASCs for 12 APCs and equalizing payment rates for E&M visits between OPDs and freestanding

offices, the impact on Medicare revenue changes is larger (Table 2-14, p. 51, and Table 2-15). About 6.5 percent of hospitals would have their overall Medicare revenue losses capped at 2 percent, which would reduce aggregate savings (program spending plus beneficiary cost sharing) from the combined policy in one year by \$160 million. The types of hospitals that would benefit the most from the stop-loss policy would be government-owned and major teaching hospitals. ■

Endnotes

- 1 In 2011, Medicare paid 80 percent more for this service when provided in an OPD than in a physician's office. The payment gap is somewhat smaller in 2013 than in 2011 because the physician office rate increased slightly and the OPPS rate decreased slightly.
- 2 The payment rates in the physician fee schedule have three parts: physician's work, practice expense, and professional liability insurance. Of the three, only practice expense differs when a service is provided in an office versus a hospital-based facility. For further information, see the Commission's *Payment basics: Physician services payment system*, available at http://www.medpac.gov/documents/MedPAC_Payment_Basics_12_Physician.pdf.
- 3 A detailed description of the OPPS can be found at *Payment basics: Outpatient hospital services payment system*, available at http://www.medpac.gov/documents/MedPAC_Payment_Basics_12_OPD.pdf.
- 4 Almost all of the practitioners in this category are physicians (e.g., in 2011, 99 percent were physicians).
- 5 According to the survey, about 30 percent of cardiologists were employed by HMOs, government-owned providers, medical schools, and other organizations in 2012.
- 6 From 2010 to 2011, the total number of echocardiograms per fee-for-service beneficiary provided in offices and the OPDs of OPPS hospitals declined by 0.2 percent and the number of nuclear cardiology services declined by 4.7 percent. These services are included in the following ambulatory payment classification (APC) groups: level I echocardiograms (APC 697), level II echocardiograms (APC 269), level III echocardiograms (APC 270), level I cardiac imaging (APC 398), and level II cardiac imaging (APC 377).
- 7 We have not examined whether OPDs would have sufficient capacity to perform all ambulatory echocardiograms and nuclear cardiology tests.
- 8 The most obvious feature of standby capacity for a hospital is the emergency department. In the OPPS, CMS has established two broad categories of APCs for payment of ED visits, Type A and Type B. A Type A ED is an "organized hospital-based facility for the provision of unscheduled episodic services to patients who present for immediate medical attention. The facility must be available 24 hours a day." A Type B facility has less stringent criteria than a Type A facility, but it is available for emergency care on an urgent basis.
- 9 For example, CPT code 99213 is for visits that typically include 15 minutes of face-to-face time between the physician and patient, whereas CPT code 99214 is for visits that typically include 25 minutes of face-to-face time between the physician and patient and involve a more detailed history and examination. This coding structure is the same whether the visit is provided in a physician's office or in an OPD.
- 10 A hospital's DSH percentage is defined as the sum of two ratios: the share of Medicare patients on Supplemental Security Income plus the share of Medicaid days over all inpatient days. The Patient Protection and Affordable Care Act of 2010 (PPACA) will affect DSH payments in two ways starting in 2014. First, PPACA will expand the pool of DSH dollars by expanding Medicaid. Second, starting in 2014, 75 percent of that expanded pool of DSH dollars will be diverted to an uncompensated care pool of dollars that will either pay for uncompensated care or be considered savings to the Medicare trust fund. For every 1 percent decline in the rate of uninsurance among those under 65 years of age, the share of the uncompensated-care pool going to hospitals will decline by 1 percent and the share allocated to Medicare trust fund savings will increase by 1 percent. The end result is that 25 percent of DSH dollars will continue to be paid out through the regular formula, and up to 75 percent of DSH dollars will be allocated for uncompensated care costs and trust fund savings.
- 11 The relative weights for most procedures in the ASC payment system are based on the relative weights in the OPPS. Consequently, the adjustments to the OPPS rates discussed here could affect payments to ASCs.
- 12 The physician fee schedule payment for 90-day global surgical codes includes the surgical procedure itself and office visits that occur within a 90-day period after the procedure. CMS assumes that the physician's clinical staff spends additional time scheduling the procedure and coordinating presurgical services when the procedure is performed in a hospital than in a physician's office. Therefore, these services are assumed to have a higher cost when delivered in an OPD. However, we are unable to estimate the amount of this additional cost. Consequently, we excluded these procedures from the group of services that are candidates for equal payment rates across settings.
- 13 APCs are collections of services defined by CPT codes that are similar both clinically and in terms of resource costs.
- 14 To identify differences in payment rates between sectors, we used payment rates from 2010 and trended them to 2012 based on the update factors in each sector. We used volume data from 2010 to identify services that were predominantly

- provided in freestanding offices. Because many services have been migrating from freestanding offices to OPDs, we also examined volume data from 2008 to identify services where at least 50 percent of total volume occurred in offices in 2008 but not in 2010. However, we did not add any APCs to our list of services based on 2008 data.
- 15 We used 100 percent of Medicare claims from 2010 to maximize the number of cases. We used $p < 0.05$ and a two-tail test to determine statistical significance.
 - 16 There are a few APCs in Group 2 for which the office rate is currently higher than the OPD rate. In these cases, the OPD rate could be increased to the level of the office rate plus the cost of additional packaging in the OPDS.
 - 17 Eighty-six percent of dual-eligible beneficiaries have incomes below 150 percent of the federal poverty level, compared with 22 percent of other beneficiaries (Jacobson et al. 2012).
 - 18 APC 269 is in Group 1. APC 270 and APC 377 are in Group 2. In 2011, these three APCs accounted for 14.5 percent of the volume of all cardiac APCs in the OPDS and 18.6 percent of the spending on all cardiac APCs in the OPDS.
 - 19 CMS uses a different method to determine ASC payment rates for new, office-based procedures. The rates for these procedures are based on the lower of the ASC rate (based on the OPDS relative weight) or the PE portion of the PFS rate that applies when the service is furnished in a physician's office. Further information about the ASC payment system can be found online at http://www.medpac.gov/documents/MedPAC_Payment_Basics_12_ASC.pdf.
 - 20 We excluded the volume of services provided in physicians' offices from this analysis. However, if we included physician office volume, the volume of 4 of the 12 APCs in this group would be higher in physicians' offices than in ASCs or OPDs. Three of these four APCs appear in Group 2. One of these four APCs (APC 247, laser eye procedures) does not appear in Group 1 or Group 2 because 90-day global surgical codes account for at least 90 percent of its volume.
 - 21 The three APCs that also appear in Group 2 are 203 (level IV nerve injections), 207 (level III nerve injections), and 239 (level II repair and plastic eye procedures).

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