

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 3-A-13

Subject: Payment Variations Across Outpatient Sites of Service
(Resolution 118-A-12; Substitute Resolution 112-A-12)

Presented by: Donna E. Sweet, MD, Chair

Referred to: Reference Committee A
(Jerry L. Halverson, MD, Chair)

1 At the 2012 Annual Meeting, the House of Delegates referred Resolution 118, which was
2 introduced by the Pennsylvania Delegation and assigned to the Council on Medical Service for a
3 report back to the House of Delegates at the 2013 Annual Meeting. At the same meeting, the House
4 of Delegates referred the second and third resolve of Substitute Resolution 112, which was
5 introduced by the Florida Delegation. The first resolve of Substitute Resolution
6 112-A-12 was referred for decision. Subsequently, the Board of Trustees deferred policymaking on
7 this issue to the Council so the first resolve of the resolution could be addressed as part of this
8 report.

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10 Substitute Resolution 112-A-12 asked:

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12 That our American Medical Association (AMA) seek legislation that requires third party
13 payers to allow their plans' qualified physicians to perform outpatient procedures at the
14 appropriate site of service (hospital outpatient department, ambulatory surgical center, or
15 office-based facility), chosen by the physician and his or her patient; and

16
17 That our AMA seek legislation requiring third party payers to require equal or lower facility
18 copayments for the lower cost alternative sites of service (hospital outpatient department,
19 ambulatory surgical center, or office-based facility) for the delivery of outpatient procedures;
20 and

21
22 That our AMA draft model state legislation to require third party payers to permit physicians
23 and patients to choose the appropriate site of service at which to perform outpatient procedures,
24 and to require equal or lower facility copayments for the lower cost alternative sites of service
25 (hospital outpatient department, ambulatory surgical center, or office-based facility).

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27 Resolution 118-A-12 asked:

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29 That our AMA advocate with Medicare, and all payers, that they pay similar amounts for
30 similar services across all ambulatory care settings.

31
32 This report provides background on the disparity in payments and patient cost-sharing for
33 procedures performed across outpatient sites of service under the Medicare program, which many
34 private payers use as a template for their own payment systems. The report focuses on payment and
35 cost-sharing variations within the framework of optimizing patient care; highlights ambulatory

1 surgical centers, which were the focus of the original Resolution 112-A-12; summarizes relevant
 2 AMA policy; and presents policy recommendations.

3
 4 **BACKGROUND**

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 6 Many surgical procedures can be safely performed in physician offices, ambulatory surgical centers
 7 (ASCs) and hospital outpatient departments (HOPDs) with no discernible effect on patient care or
 8 outcomes. Yet, the Medicare program and private insurers frequently pay substantially disparate
 9 rates and impose different patient cost-sharing amounts for the same service, depending on where it
 10 is performed. As shown in Table 1, these variations stem from the use of separate payment
 11 methodologies to determine payments to physician offices, ASCs and HOPDs. Payment systems
 12 for each setting also are subject to different annual Medicare rate updates, which further exacerbate
 13 existing payment disparities and can lead to substantially higher costs for services performed in
 14 certain settings.

15
 16 Medicare payment rates for services provided in the physician practice setting are based on the
 17 physician fee schedule. When services are provided in HOPDs or ASCs, it is assumed that practice
 18 expenses incurred in a physician’s office are instead picked up by the facility. The practice expense
 19 component of the physician payment is therefore reduced and a separate “facility fee” is made to
 20 the hospital through the Outpatient Prospective Payment System (OPPS). Surgeries performed in
 21 ASCs are paid at a percentage of the OPPS rate (in 2013, ASCs are paid approximately 56 percent
 22 of the OPPS rate¹). Services paid under the OPPS and the ASC payment systems are classified into
 23 several hundred Ambulatory Payment Classifications based on clinical and cost similarities.

24
 25 Medicare payment rates for ASCs and HOPDs are a product of a procedure’s relative weight and a
 26 conversion factor. ASC conversion factor updates are based on the consumer price index for all
 27 urban consumers (CPI-U), while OPPS updates are based on the hospital market basket. These
 28 differences typically result in higher Medicare payments for services provided in the hospital
 29 outpatient setting.

Table 1: Medicare Payment Systems for Physician Offices, Hospital Outpatient Departments, and Ambulatory Surgical Centers^{2, 3, 4}

Facility	Physician Office	Hospital Outpatient Department	Ambulatory Surgical Center
Payment System	Physician Fee Schedule (Non-Facility Rate)	Physician Fee Schedule (Facility Rate) plus OPPS rate	Physician Fee Schedule (Facility Rate) plus ASC payment tied to OPPS weights
Basis for Conversion Factor Updates	SGR	Hospital market basket	Consumer price index for all urban consumers (CPI-U)
2013 Conversion Factor	\$34.0230	\$71.537	\$43.190
2013 Payment Update	0 percent	1.8 percent	0.6 percent

30 Reductions in fee-for-service payments for certain outpatient procedures provided in physician
 31 offices, as well as growth in the number of hospital-employed physicians, have likely contributed
 32 to increases in the provision of certain services in HOPDs, even though the procedures can be
 33 safely performed in lower-cost settings.

1 Extensive and ongoing discussions have been held by the Medicare Payment Advisory
 2 Commission (MedPAC) and other stakeholders to determine whether sites of service for certain
 3 outpatient procedures are determined to some degree by financial incentives. Hospital acquisitions
 4 of freestanding ASCs and physician practices are also a concern when hospitals bill for services
 5 provided at acquired practices as if they are outpatient departments and thus eligible for higher
 6 payments. Payment variations within the Medicare program continue to be scrutinized as Congress
 7 looks for ways to rein in health care spending without negatively impacting patient care. Table 2
 8 highlights Medicare payments for five common procedures performed across outpatient settings.

Table 2: Comparison of 2013 Medicare Payments for Procedures Performed in Physician Offices, Ambulatory Surgical Centers and Hospital Outpatient Departments^{5, 6, 7}

CPT Code	Short Descriptor	Physician Office Payment (PFS Non-Facility)	Total ASC Payment (ASC + PFS Facility)	Total OPPS Payment (OPPS + PFS Facility)
20610	Drain/Inject Joint/Bursa	\$60.56	\$75.53	\$228.54
43239	Upper GI endoscopy biopsy	\$359.28	\$524.37	\$797.99
45378	Diagnostic Colonoscopy	\$410.66	\$608.39	\$911.79
69210	Remove impacted ear wax	\$53.08	\$60.51	\$82.30
99213	Office/Outpatient Visit Established Patient	\$72.81	\$72.81*	\$123.35

*Physician is paid at the PFS non-facility rate. There is no separate facility payment for E/M services performed in an ASC.

9 **AMBULATORY SURGICAL CENTERS**

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 11 ASCs provide outpatient surgical procedures exclusively to patients who do not require overnight
 12 hospital stays. These entities can be freestanding or hospital-based, and most have at least one
 13 physician owner. The most commonly performed procedures in the ASC setting include cataract
 14 removal, upper gastrointestinal endoscopy and colonoscopy.

15
 16 Medicare revised ASC payment policy in 2008 to expand the number of covered procedures and
 17 reimburse facility-related costs (e.g., nursing, recovery, lab testing, and drugs) based on a
 18 percentage of the OPPS rate.⁸ Despite these revisions, Medicare payments remain lower for most,
 19 but not all, procedures performed in ASCs when compared to HOPDs. Patient characteristics could
 20 account for some of this variability since HOPDs have emergency and standby capacity and are
 21 better suited to treat medically complex patients. HOPDs also serve more Medicaid patients and
 22 may be the only available facility in areas where ASCs have little or no market share.

23
 24 In 2011, 3.4 million Medicare beneficiaries received services in 5,344 ASCs at a cost of
 25 \$3.4 billion.⁹ These amounts represent a deceleration in growth from earlier years when ASCs
 26 experienced more robust expansion. Since October 2012, ASCs have been required to submit
 27 quality of care data to CMS. MedPAC has also recommended a value-based purchasing program
 28 for ASCs; however, Congress has not yet required ASCs to submit cost data.¹⁰

29
 30 **PRIVATE PAYERS AND BENEFICIARY COST-SHARING**

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 32 Private insurers vary with respect to payments and cost-sharing across outpatient sites of service.
 33 Many follow the Medicare program and pay higher facility fees for procedures performed in
 34 HOPDs.

1 Some incentivize using ASCs for appropriate surgical procedures as a way to lower costs. Less
2 frequently, private payers use coverage policies to steer patients toward HOPDs with whom they
3 may have contractual arrangements. Insurers can also decline to cover certain facilities, including
4 ASCs, or consider them out-of-network, regardless of cost or the quality of patient care.

5
6 Patient cost-sharing also varies depending on the insurer and its coverage policies regarding
7 outpatient sites of service. Private payers may use tiered cost-sharing to encourage patients to use
8 lower-cost settings. Patients may not understand the dollar amount of cost-sharing they will incur
9 for procedures performed in a particular setting. Furthermore, it is unlikely that patients or the
10 public at large are fully aware of the disparities in health care costs between procedures performed
11 in physician offices, ASCs and HOPDs.

12
13 Medicare beneficiaries typically pay 20 percent coinsurance for outpatient procedures but can pay
14 significantly more than 20 percent for some services in the HOPD. The total amount of coinsurance
15 paid for HOPD services cannot surpass that year's inpatient prospective payment system
16 deductible. There are no limits on beneficiary coinsurance for procedures performed in an ASC.
17 Since most Medicare beneficiaries use supplemental coverage for cost-sharing expenses, there is
18 little incentive for patients to choose outpatient settings that offer lower out-of-pocket liability.

19 20 RELEVANT AMA POLICY

21
22 The AMA has extensive policy addressing payment variations across outpatient sites of service.
23 Policy H-330.925 encourages CMS to: fairly pay physicians for office-based procedures; adopt a
24 single facility payment schedule for HOPDs and ASCs; and use valid and reliable data in the
25 development of payment methodology for the provision of ambulatory services. The same policy
26 directs the AMA to lobby for any needed changes to regulations affecting payments to ASCs to
27 assure a fair rate of payment. AMA policy also supports encouraging CMS to adopt payment
28 methodology that will assist in leveling the playing field across all sites of service (Policy
29 D-330.997), and shifting procedures from the hospital to the office setting, which is more cost
30 effective (Policy H-400.957). Policy H-240.993 further supports equity of payment between
31 services provided in the HOPD and similar services in physicians' offices.

32
33 With regard to private payers, AMA policy supports balanced third party coverage of alternative
34 services and settings, and opposes payment policies that discourage provision of care in the most
35 cost-effective setting (Policy H-385.992), and also calls for payment policies to encourage use of
36 the most cost-effective care setting in which services can be provided safely with no detriment to
37 quality (Policy H-285.951). The AMA also urges third party payers to include facility fee payments
38 for procedures using more than local anesthesia in accredited office-based surgical facilities (Policy
39 H-385.916), but not to discriminate between hospital and independently-owned outpatient facilities
40 with respect to payment of "facility" costs (Policy H-240.979).

41
42 AMA policy acknowledges that health care plans or networks may develop and use criteria to
43 determine the number, geographic distribution, and specialties of physicians needed (Policy
44 H-285.984), but supports efforts that would prohibit health care plans with certain market power
45 from denying physicians access to their networks (Policy H-285.992).

46
47 Additional policy supports patient choice of health care providers (Policies H-285.914; H-373.998;
48 and H-415.988); physician decision-making on choice of service sites (Policies H-285.954 and
49 H-475.994); and physician supervision of patient care in ambulatory settings (Policy H-70.991).
50 Unfair copayments are addressed in Policy H-185.983, which condemns the practice of basing
51 copayments on a basis other than third party payments.

1 Policy H-165.846 supports educating patients and assisting them in making informed choices,
2 including ensuring transparency among all health plans regarding covered services, cost-sharing,
3 out-of-pocket limits and lifetime benefit caps, and excluded services. Policy H-185.975 states that
4 third party payers and self-insured plans should publish their payment policies, rules and fee
5 schedules. Policy D-155.990 directs the AMA to actively oppose legislation or regulations that
6 deem the physician the responsible party to inform patients of their health care costs. Transparency
7 of health care costs and patient cost-sharing are also addressed by Policies H-185.985,
8 H-285.998[5] and H-450.938.

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10 DISCUSSION

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12 The AMA has extensive policy calling for fair and equitable Medicare payments for procedures
13 performed in various outpatient settings. Accordingly, the Council believes the AMA should
14 reaffirm Policies H-330.925, H-240.993 and D-240.993, and focus new policy on private payers
15 and patient cost-sharing.

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17 Consistent with AMA Policy H-155.960, which promotes value-based decision making at all
18 levels, payments, as well as coinsurance for outpatient procedures, should be tiered by site and
19 level of service (office-based, ASC or HOPD) to create incentives for private payers and
20 beneficiaries to choose lower-cost settings if they are safe and clinically appropriate. Accordingly,
21 the Council believes the AMA should work with states to require third party payers to require equal
22 or lower facility coinsurance for lower-cost sites of service.

23
24 The Council discussed variations in payment and cost-sharing across outpatient sites of service as a
25 means of addressing health care costs, and also within the framework of patient care and safety.
26 The policy priority established by the Council is to ensure patients' access to services in the most
27 clinically appropriate setting, depending on their needs and the severity of their conditions.
28 Physicians are responsible for assessing patient comorbidities, the risks associated with specific
29 outpatient procedures, and the level of outpatient care that is needed to ensure the best health
30 outcomes. Therefore, the Council believes the AMA should work with states to advocate that third
31 party payers be required to allow their plans' participating physicians to perform outpatient
32 procedures at an appropriate site of service as chosen by the physician and the patient. Ideally,
33 patients should be fully aware of their coinsurance obligations, and the Council recommends
34 reaffirming Policy H-165.846, which supports mechanisms to educate patients and assist them in
35 making informed choices. The Council also recommends that the AMA work with states to
36 advocate that third party payers publish and routinely update pertinent information related to
37 patient cost-sharing.

38
39 MedPAC and other stakeholders have discussed ways to create parity between payments for certain
40 services across outpatient settings. While an HOPD is the appropriate setting for many outpatient
41 procedures, particularly those involving medically complex patients, the recent migration of certain
42 services into HOPDs from other ambulatory settings is garnering attention because of increased
43 costs to the Medicare program. As stated previously, payment systems for each setting are subject
44 to different annual Medicare updates which will lessen the impact of equalization efforts that do
45 not address underlying payment methodologies.

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47 The Council also acknowledges the concerns raised by some physicians that attempts to equalize
48 payments could actually reduce payments to all providers regardless of site of service. The cost
49 impact on hospitals, particularly disproportionate share hospitals, could lead to barriers to patient
50 access.

1 RECOMMENDATIONS

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The Council on Medical Service recommends that the following be adopted in lieu of Resolution 118-A-12 and the second and third resolve of Substitute Resolution 112-A-12, and that the remainder of this report be filed:

1. That our American Medical Association (AMA) reaffirm Policies H-330.925, H-240.993 and D-330.997, which support equitable Medicare payments across outpatient settings. (Reaffirm HOD Policy)
2. That our AMA reaffirm Policy H-165.846, which supports mechanisms to educate patients and assist them in making informed choices, including ensuring transparency among all health plans regarding covered services, cost-sharing, out-of-pocket limits and lifetime benefit caps, and excluded services. (Reaffirm HOD Policy)
3. That our AMA work with states to advocate that third party payers be required to:
 - a. Assess equal or lower facility coinsurance for lower-cost sites of service (hospital outpatient department, ambulatory surgical center, or office-based facility);
 - b. Publish and routinely update pertinent information related to patient cost-sharing; and
 - c. Allow their plan's participating physicians to perform outpatient procedures at an appropriate site of service as chosen by the physician and the patient. (Directive to Take Action)

Fiscal Note: Less than \$500.

References

¹ Analysis of Medicare's 2013 Payment Rule. Ambulatory Surgery Center Association. November 2, 2012.

² MedPAC Meeting Presentation. Assessing Payment Adequacy: Ambulatory Surgical Center Services. January 10, 2013. MedPAC.

Available at: <http://www.medpac.gov/transcripts/ASC%20Jan%202013%20public.pdf>

³ March 2013 Report to the Congress: Medicare Payment Policy. March 2013. MedPAC.

Available at: http://www.medpac.gov/documents/Mar13_EntireReport.pdf

⁴ Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Electronic Reporting Pilot; Inpatient Rehabilitation Facilities Quality Reporting Program; Revision to Quality Improvement Organization Regulations; Final Rule. Department of Health and Human Services, Centers for Medicare & Medicaid Services. November 15, 2012.

Available at: <http://www.gpo.gov/fdsys/pkg/FR-2012-11-15/pdf/2012-26902.pdf>.

⁵ RBRVS DataManager Online. American Medical Association.

Available at: <https://commerce.ama-assn.org/ocm/catalog/product.jsp?id=prod280002&event=view>.

⁶ The CY2013 Ambulatory Surgical Center Payment Final Rule, Addendum AA – Final ASC Covered Surgical Procedures. 2013. Department of Health and Human Services. Centers for Medicare & Medicaid Services.

Available at: <http://www.cms.gov/apps/ama/license.asp?file=/ascpayment/downloads/CMS-1589-FC-ASC-addenda-FN13.zip>.

⁷ The CY2013 Hospital Outpatient Prospective Payment - Final Rule with Comment Period. Department of Health and Human Services. Centers for Medicare & Medicaid Services.

Available on the CMS website at: <http://cms.hhs.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1589-FC.html>.

⁸ Ambulatory Surgical Center Services Payment System. MedPAC. Revised October 2011.

⁹ MedPAC Meeting Presentation. Assessing Payment Adequacy: Ambulatory Surgical Center Services. January 10, 2013. MedPAC.

Available at: <http://www.medpac.gov/transcripts/ASC%20Jan%202013%20public.pdf>

¹⁰ MedPAC Meeting Presentation. Assessing payment adequacy: physician, other health professional, and ambulatory surgical center services. December 6, 2012.