Getting the most for our health care dollars

Payment variations across outpatient sites of service

As the nation’s health care system continues to evolve, the American Medical Association is dedicated to ensuring sustainable physician practices that deliver high-quality health care at an affordable cost. Addressing the variations in physician payments across outpatient sites of service—and using less costly settings for service delivery—can reduce health care costs and help foster long-term practice sustainability and greater physician satisfaction.

Background

Outpatient medical procedures are performed in a variety of settings including physician offices, hospital outpatient departments (HOPDs) and ambulatory surgical centers (ASCs). While choosing an outpatient site may have no discernible effect on patient care it does, however, categorically influence that service’s price. For example, the cost of an echocardiogram is much higher when it is provided in an HOPD instead of a physician’s office. Similarly, a colonoscopy provided in an HOPD is more expensive than a colonoscopy furnished in an ASC. Patients may be unaware of these cost differentials, or that their cost-sharing responsibilities also vary by outpatient setting.

Generally speaking, the Medicare program pays higher rates for outpatient procedures provided in hospitals than what is paid to physician offices and ASCs for furnishing the same services. Under Medicare, hospital-acquired physician practices and ASCs meeting certain criteria (e.g., are located within 35 miles of the hospital) could be converted to HOPDs and charge higher hospital rates for services performed at these off-campus facilities. The Bipartisan Budget Act (BBA) of 2015 disallows provider-based billing by hospitals for newly acquired, off-campus physician practices and ASCs. Beginning in 2017, off-campus entities acquired after enactment of the BBA will no longer be permitted to bill for services under the hospital outpatient prospective payment system (OPPS).

Private insurers, like the Medicare program, spend more on outpatient procedures performed in hospital settings, as do patients through higher cost-sharing. While hospitals may be the most clinically appropriate setting for patients to receive certain outpatient procedures (e.g., patients who are medically complex or live in areas lacking freestanding ASCs), the migration of services into HOPDs from less costly ambulatory sites of service, attributed in part to hospital acquisition of physician offices and ASCs, has significantly increased outpatient expenditures. Furthermore, patients may not fully understand whether outpatient entities are independent or hospital-owned, and how a site’s designation can impact service cost and their cost-sharing. Accordingly, payment variations within the Medicare program continue to be scrutinized as Congress looks for ways to rein in health care spending without negatively impacting patient care.

SPOTLIGHT:
Ambulatory surgical centers

Ambulatory surgical centers (ASCs) provide outpatient surgical procedures exclusively to patients who do not require overnight hospital stays. These entities can be freestanding or hospital-based. Medicare revised ASC payment policy to expand the number of covered procedures and reimburse facility-related costs (e.g., nursing, recovery, lab testing and drugs) based on a percentage of the hospital outpatient prospective payment system rate. Nevertheless, Medicare payments remain lower for most procedures performed in ASCs when compared to HOPDs.
Why payments vary across outpatient sites of service

Payment variations across different outpatient sites stem from the Medicare program’s use of different payment methodologies for each outpatient setting. For services performed in physician offices, Medicare payments are based on the physician fee schedule. For procedures provided in HOPDs or ASCs, Medicare pays a reduced amount for physician services plus a facility fee established under the OPPS. In ASCs, payment is also based on the non-facility fee schedule amount and a separate facility fee that is set using a procedure’s relative weight as well as a conversion factor that assigns a price tag to the relative weight.

Medicare spending varies between these outpatient settings because the weights vary, and conversion factors for the OPPS and the ASC payment system are based on different measures of inflation. The Medicare program uses the consumer price index for all urban consumers, a measure highly weighed for housing and transportation, to annually update the ASC conversion factor. OPPS updates are based on the hospital market basket. The difference causes Medicare payment rates and patient cost-sharing for most outpatient procedures furnished in ASCs to be significantly less than the cost of the same services provided in a hospital. In 2016 ASCs were paid approximately 53 percent of the OPPS rate for furnishing the same outpatient procedures as HOPDs.

<table>
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<th>Site</th>
<th>Physician office</th>
<th>Hospital outpatient department</th>
<th>Ambulatory surgical center</th>
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<td>Medicare Access and CHIP Reauthorization Act and Achieving a Better Life Experience Act</td>
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How to get the most for our health care dollars

- **Support equitable Medicare payments across outpatient settings**
  The AMA strongly supports equitable Medicare payments across outpatient sites of service. AMA policy encourages the Centers for Medicare & Medicaid Services to pay physicians fairly for office-based procedures; adopt a single facility payment schedule for HOPDs and ASCs; and use valid and reliable data to develop payment methodologies for the provision of ambulatory services.

- **Incentivize cost-effective care**
  Payment policies should encourage use of the most cost-effective care setting in which services can be provided safely and with no detriment to quality. The AMA believes physician payments and patient cost-sharing should be tiered by site and level of service (physician office, ASC or HOPD), so that patients are incentivized to receive outpatient services in lower-cost settings. Accordingly, the AMA believes that third party payers should assess equal or lower facility coinsurance for lower-cost sites of service when quality is not at issue.

- **Help patients make informed choices**
  The AMA supports educating patients and assisting them in making informed choices, including ensuring transparency among all health plans regarding patient cost-sharing, out-of-pocket limits, out-of-network costs, lifetime benefit caps and excluded services. The AMA believes that third party payers should publish and routinely update pertinent information related to patient cost-sharing, out-of-pocket limits, out-of-network costs, lifetime benefit caps and excluded services. Furthermore, the AMA believes that patients should be allowed to receive outpatient procedures at the most clinically appropriate site of service as chosen by the physician and the patient.