CHAPTER 8

Aligning fee-for-service payment rates across ambulatory settings

RECOMMENDATION

8 The Congress should more closely align payment rates across ambulatory settings for selected services that are safe and appropriate to provide in all settings and when doing so does not pose a risk to access.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

CHAPTER 8

Aligning fee-for-service payment rates across ambulatory settings

Chapter summary

Medicare fee-for-service (FFS) payment rates often differ for the same service across ambulatory settings (hospital outpatient departments (HOPDs), ambulatory surgical centers (ASCs), and freestanding physician offices). These payment differences encourage arrangements among providers, such as consolidation of physician practices with hospitals, that result in care being billed from settings with the highest payment rates, which increases total Medicare spending and beneficiary cost sharing without significant improvements in patient outcomes. From 2015 to 2021, for example, the volume of chemotherapy administration in freestanding clinician offices, the ambulatory setting for which payment rates are usually lowest, fell 14.2 percent, while the volume in HOPDs, the ambulatory setting for which payment rates are usually highest, climbed 21.0 percent.

In general, the Commission maintains that Medicare should base payment rates on the resources needed to treat patients in the most efficient setting. If the same service can be safely and appropriately provided in different settings, a prudent purchaser should not pay more for that service in one setting than in another. This principle suggests that—for services that are safe and appropriate to provide in a lower-cost setting—Medicare should more closely align FFS payment rates across ambulatory

In this chapter

settings. However, Medicare should be selective about which services should have payment rates aligned across settings, as many ambulatory services cannot be safely or appropriately provided in freestanding offices in the majority of circumstances. Such services are typically complex procedures or services related to emergency care. In these instances, discretion should be used and the payment rates in each of the ambulatory settings should be left unchanged to ensure that hospitals are adequately reimbursed to maintain access to those services.

Adjusting rates paid for certain services delivered in higher-cost settings to more closely align with the rates paid in lower-cost settings in which it is safe to provide the service would reduce incentives to shift the billing of Medicare services from low-cost settings to high-cost settings. The result would be lower Medicare program spending, lower beneficiary cost sharing, and an incentive for providers to improve efficiency by caring for patients in the lowest-cost site appropriate for their condition.

In our June 2022 report to the Congress, we discussed a method to identify the services for which it might be appropriate to align payment rates across HOPDs, ASCs, and freestanding offices. To identify such services, we modeled an approach based on the volume for each service in each setting.

If freestanding offices had the highest volume for a service, it would arguably be safe to provide that service in freestanding offices for most beneficiaries. Therefore, our model aligns the payment rates in the outpatient prospective payment system (OPPS) (the payment system for most services provided in HOPDs) and the ASC payment system with the payment rates from the fee schedule for physicians and other health professionals, also known as the physician fee schedule (PFS).

If ASCs had the highest volume for a service, we aligned the OPPS payment rate with the ASC payment rate and left the PFS payment rate unchanged.

If HOPDs had the highest volume for a service, we determined that it likely was not safe to provide that service outside the HOPD setting for a majority of beneficiaries. Moreover, for these services, aligning OPPS payment rates with those from a lower-cost setting could adversely affect beneficiaries' access to those services. Hence, for these services, we left the payment rates unchanged.

In this chapter, we updated our analysis using more recent data. We identified 57 ambulatory payment classifications (APCs) (the payment classifications used

in the OPPS and ASC system) for which freestanding offices had the largest volume. For the services in these APCs, we aligned the OPPS payment rates and ASC payment rates more closely with the PFS payment rates for the services. We also identified nine APCs for which ASCs had the highest volume; for the services in those APCs, we aligned the OPPS payment rates with the ASC payment rates. For the remaining 103 APCs, HOPDs had the highest volume, so we made no changes to the payment rates in each of the three ambulatory settings. Because current law requires changes to OPPS and ASC payment rates to be implemented on a budget-neutral basis, payment alignment would reduce payments for the 66 selected APCs but would increase payment rates for all other APCs for which we determined that payment rate alignment was not appropriate. As a result, aggregate spending in the short term would be unchanged. However, aligning payment rates for select services would reduce incentives for providers to make site-of-care decisions based on financial rather than clinical factors, which could eventually result in lower aggregate spending.

We note that the services we identified for payment rate alignment are not necessarily the specific services that CMS would select for alignment under its own processes since CMS could use a different approach for the initial identification of candidate services, and the selection could be informed by clinicians or other stakeholders through notice-and-comment rulemaking or similar processes.

Further, a well-functioning system of aligning payment rates should ensure that hospitals receive financial support to maintain access to emergency care and standby capacity. Emergency departments that are part of a hospital are subject to the Emergency Medical Treatment and Active Labor Act of 1986, which requires them to screen and stabilize (or transfer) patients who are experiencing a medical emergency, regardless of their ability to pay. Under the OPPS, the payment rates for services provided during emergency care reflect the additional costs that hospitals incur to maintain emergency departments. Sometimes, emergency care includes the services that we deemed appropriate for payment alignment in our model. In these instances, the aligned payment rate may not be high enough to adequately reimburse hospitals for the cost of emergency care. Consequently, when services with aligned payment rates are provided as part of an emergency department visit, hospitals should receive a payment rate that is above the aligned amount.

Based on the recent growth in hospital acquisition of physician practices and our own empirical analysis, the Commission recommends that the Congress more closely align payment rates across ambulatory settings for selected services that are safe and appropriate to provide in all settings and when doing so does not pose a risk to access. In the context of the OPPS's current-law budget-neutrality requirement, this recommendation would have no immediate effect on total Medicare revenue for OPPS hospitals in aggregate. Over time, however, this recommendation could have an indirect effect on program spending because it would reduce incentives for hospitals to acquire physician practices and bill for services under the usually higher-paying OPPS. This recommendation would have differing effects across hospitals, as some would see Medicare revenue gains while others would experience revenue losses. Despite the potential losses for some hospitals, this recommendation would not be expected to affect providers' willingness or ability to furnish the affected services. Any concerns about specific hospital categories being adversely affected should be addressed through targeted assistance to those hospitals rather than maintaining higher-than-warranted OPPS payment rates for some services. ■

Introduction

A persistent problem in fee-for-service (FFS) Medicare is that differences in prices across care settings that provide similar services distort provider incentives. Payment rates for services covered under the outpatient prospective payment system (OPPS)—which is the system of payment for most services provided to Medicare beneficiaries in hospital outpatient departments (HOPDs)—are generally higher than the payment rates for similar services covered under Medicare's fee schedule for physicians and other health professionals, also known as the physician fee schedule (PFS). For example, in 2023, Medicare pays 194 percent more in an HOPD than in a freestanding office for a transthoracic echocardiogram with image documentation. In FFS Medicare, payment rate differences among similar settings occur among ambulatory settings (clinician offices, HOPDs, and ambulatory surgical centers (ASCs)) and among post-acute care (PAC) settings (skilled nursing facilities, inpatient rehabilitation facilities, long-term care hospitals, and home health care).

To address incentives for providers to shift the billing of services to higher-cost settings, the Commission has published several reports that encourage reducing payment rates in more costly settings so that they more closely align with payment rates in lower-cost settings for similar services. These reports include aligning payments for select services in HOPDs and freestanding physician offices (Medicare Payment Advisory Commission 2014, Medicare Payment Advisory Commission 2013, Medicare Payment Advisory Commission 2012); aligning payment rates for nonchronically ill patients treated in long-term care hospitals with payment rates for acute care hospitals (Medicare Payment Advisory Commission 2014); aligning payment rates between skilled nursing facilities and inpatient rehabilitation facilities (Medicare Payment Advisory Commission 2015); and implementing a unified prospective payment system for PAC services (Medicare Payment Advisory Commission 2019, Medicare Payment Advisory Commission 2017, Medicare Payment Advisory Commission 2016). In general, the Commission has maintained that Medicare should base payment rates on the resources needed to treat patients in the most efficient, clinically appropriate setting. 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. In our June 2022 report to the Congress, we discussed a method to more closely align payment rates across HOPDs, ASCs, and freestanding offices (Medicare Payment Advisory Commission 2022). We modeled this payment alignment to examine the impacts on Medicare spending, beneficiary cost sharing, and hospital revenue. In this chapter, we update our model results and recommend that the Congress and the Secretary move forward with a payment alignment policy for the three ambulatory settings.

Billing for many services has shifted from the physician fee schedule to the outpatient prospective payment system

Because of the payment rate differences across clinician offices, HOPDs, and ASCs, hospitals have an incentive to acquire physician practices and then bill for the same services under the OPPS, thereby increasing revenue without a meaningful change in the site of care. Indeed, billing for many ambulatory services has been shifting from the PFS to the OPPS. Analysis of data from the American Medical Association's Physician Practice Benchmark Surveys indicates that the share of physicians who were either in practices at least partially owned by hospitals or that were employees of hospitals increased from 29.0 percent in 2012 to 39.8 percent in 2020 (Kane 2021).

As hospitals acquire more physician practices and more physicians become employed by hospitals, service billing shifts from the PFS to the OPPS—with its usually higher payment rates—even if there is no actual change to the physical setting in which the service is provided or in the delivery of the service itself. Among evaluation and management (E&M) office visits, echocardiograms, nuclear cardiology, and chemotherapy administration services, for example, the share of total volume of services billed under the OPPS increased from 2012 to 2021 (Table 8-1, p. 358). As billing of services shifts from the PFS to the OPPS, program spending and beneficiary cost sharing increase without significant changes in patient care.

TABLE 8–1 **Billing of important ambulatory services has shifted from the PFS to the OPPS**

Service	Share in OPPS 2012	2021
Office visits	9.6%	12.8%
Chemotherapy administration	35.2	51.9
Nuclear cardiology	33.9	47.6
Echocardiography	31.6	43.1

Note: PFS (physician fee schedule), OPPS (outpatient prospective payment system).

Source: MedPAC analysis of standard analytic claims files, 2012 and 2021.

The incentive for hospitals to acquire physician practices was mitigated (but not eliminated) by the Bipartisan Budget Act (BBA) of 2015, through which the Congress directed CMS to develop a limited system that more closely aligns payment rates between HOPDs and freestanding offices. CMS satisfied this mandate in 2017 by implementing payment rates that approximate PFS rates for certain services provided in off-campus provider-based departments (PBDs) of hospitals that were not providing services when the Congress enacted the BBA of 2015 on November 2, 2015 (Centers for Medicare & Medicaid Services 2016). However, the off-campus PBDs not subject to the BBA of 2015 site-neutral payments have no restrictions on expanding the range of services they provide. Therefore, when a hospital acquires a physician practice and adds it to an existing off-campus PBD that is excepted from the BBA of 2015, the services furnished by that practice are paid at full OPPS rates (with the exception of office visits).

Some stakeholders have argued that Medicare should pay HOPDs higher rates for all services so that hospitals can use the higher payments to subsidize 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 distorts prices, which has the unintended consequence of giving hospitals an incentive to acquire physician practices. For example, paying much more for chemotherapy administration in HOPDs than freestanding offices encourages hospitals to purchase oncology practices and bill for chemotherapy as a hospital outpatient service without any change in the physical location. Therefore, higher OPPS payment rates that support hospitals' standby capacity should be limited to select services that are directly related to hospitals' standby capacity, such as visits for emergency and trauma care and services provided as part of those visits.

Stakeholders have further argued that Medicare should not align any HOPD rates with physician office rates because hospitals incur higher overhead costs than freestanding physician offices. For example, hospitals must comply with more stringent building codes, life-safety codes, and hospital-level staffing requirements. In addition, hospitals must incur the cost of financially integrating the HOPD into the hospital and billing patients a separate facility fee (in addition to the physician's fee). However, if patient severity is similar and a service can be provided in a lower-cost setting without a reduction in quality or safety, the Commission maintains that Medicare should pay a rate based on the lower-cost setting.

Identifying ambulatory services for payment rate alignment

Among the three ambulatory settings, the PFS has the lowest payment rate for most services

that are furnished in all three settings. The most straightforward approach to aligning payment rates would be to establish rates that are equal to PFS rates in all three ambulatory settings. However, payment rates for all services provided in the three settings should not simply be set to the payment rates for the lowest-price setting for a number of reasons:

- HOPDs differ from freestanding offices and ASCs in ways that can lead to higher costs in HOPDs for certain services. For example, some services have costs associated with maintaining standby emergency capacity. Emergency departments (EDs) that are part of a hospital are subject to the Emergency Medical Treatment and Active Labor Act of 1986, which requires them to screen and stabilize (or transfer) patients who are experiencing a medical emergency, regardless of their ability to pay. Medicare payments for services provided in EDs include these standby costs, and therefore they are not, and should not be, equal to freestanding office rates for similar services.
- Some services can be safely provided only in HOPDs for most beneficiaries, so it is beneficial to protect services in this context from site-neutral payments.
- The payment bundle in the OPPS and the ASC payment system is typically a primary service with related ancillary items, while the PFS generally provides payment for ancillary items that is separate from payment for the primary service. This difference in payment bundles must be considered when aligning payment rates across settings.

In this chapter, we update our June 2022 analysis of the effects of aligning payment rates across ambulatory settings. We identified services for which payment rate alignment could be reasonable using the following steps:

- We sorted services into ambulatory payment classifications (APCs), which are the payment classifications used in the OPPS and (generally) the ASC system. APCs are made up of services represented by codes in the Healthcare Common Procedure Coding System (HCPCS). CMS classifies HCPCS codes that are similar in terms of cost and clinical attributes in the same APC. All HCPCS codes in the same APC have the same OPPS payment rate. Likewise, all HCPCS codes in the same APC have the same payment rate under the ASC system, but the ASC payment rates are lower than the OPPS payment rates for the same services.
- Some APCs include services that can be reasonably provided only in HOPDs because freestanding offices and ASCs do not have the infrastructure to provide those services. Examples include emergency care and trauma care. It is vital that these services continue to be paid at full OPPS payment rates, so we removed these APCs from consideration of payment rate alignment.
- For the remaining APCs, we sought to align payment rates with the lowest cost setting in which it is safe to provide the services in the APC for most beneficiaries. To do so, we compared the volume of services in each APC that was provided in HOPDs, ASCs, and freestanding offices over the period of 2016 through 2021, but we omitted 2020 because the coronavirus pandemic affected the volume of care in ambulatory settings.
  - If freestanding offices had the highest volume for an APC, we concluded that the services in that APC could be provided safely in freestanding offices for most beneficiaries and that beneficiaries would be able to access the services in that APC. Therefore, for those services, it would be reasonable to align the OPPS and ASC payment rates with the PFS payment rates.
  - Similarly, if ASCs had the highest volume for an APC, that APC's services could arguably be provided safely in ASCs for most beneficiaries. Therefore, OPPS payment rates could be aligned with the ASC payment rates for those services. Freestanding offices would still be paid PFS rates for those services.
  - If HOPDs had the highest volume for an APC, it might not be safe to provide those services outside the HOPD setting for most Medicare beneficiaries. In addition, we would be concerned about beneficiaries' access to those services if HOPD payments were aligned with either PFS or ASC payment rates. We therefore determined that, for these APCs, HOPDs should continue to be paid OPPS payment rates, ASCs

TABLE 8-2

Program spending, beneficiary cost sharing, and volume for 57 APCs for which we aligned OPPS payment rates with PFS payment rates, 2021

APC	APC description	Program spending (in millions)	Beneficiary cost sharing (in millions)	Volume (in thousands)
5012	Clinic visits	$2,056	$514	27,835
5693	Level 3 drug administration	879	220	5,459
5694	Level 4 drug administration	680	170	2,819
5524	Level 4 imaging w/o contrast	680	170	1,778
5593	Level 3 nuclear medicine	642	160	619
5522	Level 2 imaging w/o contrast	632	158	7,333
5523	Level 3 imaging w/o contrast	547	137	3,000
5521	Level 1 imaging w/o contrast	453	113	7,072
5052	Level 2 skin procedures	288	72	1,048
5691	Level 1 drug administration	283	71	8,987
5373	Level 3 urology and related services	240	60	169
5443	Level 3 nerve injections	238	59	364
5054	Level 4 skin procedures	230	58	169
5442	Level 2 nerve injections	223	56	443
5724	Level 4 diagnostic tests and related services	191	48	267
5692	Level 2 drug administration	189	47	3,963
5441	Level 1 nerve injections	176	44	873
5722	Level 2 diagnostic tests and related services	141	35	671
5611	Level 1 therapeutic radiation treatment preparation	136	46	1,454
5051	Level 1 skin procedures	102	26	722
5822	Level 2 health and behavior services	95	24	1,596
5053	Level 3 skin procedures	78	20	190
5734	Level 4 minor procedures	77	19	871
5071	Level 1 excision/biopsy/incision and drainage	76	19	154
5372	Level 2 urology and related services	69	17	153
5723	Level 3 diagnostic tests and related services	65	16	169
5733	Level 3 minor procedures	60	15	1,360
5823	Level 3 health and behavior services	58	14	558
5101	Level 1 strapping and cast application	51	13	454
5721	Level 1 diagnostic tests and related services	49	12	447
5153	Level 3 airway endoscopy	46	11	39
5731	Level 1 minor procedures	34	9	1,751
5371	Level 1 urology and related services	34	8	160
5671	Level 1 pathology	31	8	768
5164	Level 4 ENT procedures	29	7	13
5741	Level 1 electronic analysis of devices	28	7	955
5055	Level 5 skin procedures	28	7	10

TABLE 8-2

Program spending, beneficiary cost sharing, and volume for 57 APCs for which we aligned OPPS payment rates with PFS payment rates, 2021 *(cont.)*

APC	APC description	Program spending (in millions)	Beneficiary cost sharing (in millions)	Volume (in thousands)
5481	Laser eye procedures	$20	$5	52
5151	Level 1 airway endoscopy	16	4	127
5111	Level 1 musculoskeletal procedures	10	2	58
5163	Level 3 ENT procedures	8	2	8
5732	Level 2 minor procedures	8	2	305
5743	Level 3 electronic analysis of devices	7	2	34
5102	Level 2 strapping and cast application	7	2	36
5161	Level 1 ENT procedures	7	2	41
5152	Level 2 airway endoscopy	6	1	19
5413	Level 3 gynecologic procedures	4	1	8
5411	Level 1 gynecologic procedures	4	1	29
5412	Level 2 gynecologic procedures	4	1	17
5162	Level 2 ENT procedures	3	1	9
5742	Level 2 electronic analysis of devices	3	1	36
5502	Level 2 extraocular, repair, and plastic eye procedures	2	1	4
5501	Level 1 extraocular, repair, and plastic eye procedures	2	1	12
5735	Level 5 minor procedures	1	0.3	7
5821	Level 1 health and behavior services	1	0.3	66
5621	Level 1 radiation therapy	1	0.3	12
5811	Manipulation therapy	0.5	0.1	25

Note: APC (ambulatory payment classification), OPPS (outpatient prospective payment system), PFS (physician fee schedule), ENT (ear, nose, and throat). "Program spending" indicates outlays by the Medicare program and excludes beneficiary cost sharing. For all APCs listed, "beneficiary cost sharing" is 25 percent of program spending except for APC 5611, for which the beneficiary copayment is capped at a historical copayment level.

Source: MedPAC analysis of 100 percent standard analytic claims files from 2021 and MedPAC analysis of payment rates in the 2021 OPPS.

should continue to be paid ASC payment rates, and freestanding offices should continue to be paid PFS rates.

The OPPS has 169 APCs for health care services.[1] We identified 63 APCs for which freestanding offices had the largest volume. However, six of these APCs have a substantial amount of packaging (i.e., bundling of ancillary items provided with the service) under the OPPS, and some of the HCPCS codes within these APCs have low volume in freestanding offices and high volume in HOPDs. Therefore, we determined that it would be appropriate to maintain differential payment rates for these six APCs.

For the services in the remaining 57 APCs for which freestanding offices had the largest volume, we aligned the OPPS payment rates and ASC payment rates more closely with the PFS payment rates (Table 8-2). We also identified nine APCs for which ASCs had the

TABLE 8-3

Program spending, beneficiary cost sharing, and volume for nine APCs for which we aligned OPPS payment rates with ASC payment rates, 2021

APC	APC description	Program spending (in millions)	Beneficiary cost sharing (in millions)	Volume (in thousands)
5312	Level 2 lower GI procedures	$725	$181	877
5491	Level 1 intraocular procedures	568	142	343
5431	Level 1 nerve procedures	221	55	159
5311	Level 1 lower GI procedures	215	54	339
5492	Level 2 intraocular procedures	212	53	68
5112	Level 2 musculoskeletal procedures	92	23	83
5462	Level 2 neurostimulator and related procedures	69	17	14
5503	Level 3 extraocular, repair, and plastic eye procedures	40	10	25
5504	Level 4 extraocular, repair, and plastic eye procedures	13	3	5

Note: APC (ambulatory payment classification), OPPS (outpatient prospective payment system), ASC (ambulatory surgical center), GI (gastrointestinal). "Program spending" indicates outlays by the Medicare program and excludes beneficiary cost sharing. For all APCs listed, "beneficiary cost sharing" is 25 percent of program spending.

Source: MedPAC analysis of 100 percent standard analytic claims files from 2021 and MedPAC analysis of payment rates in the 2021 OPPS.

highest volume (Table 8-3, p. 362). For the services in those APCs, we aligned the OPPS payment rates with the ASC payment rates. For the remaining 103 APCs, HOPDs had the highest volume, and we made no changes to the payment rates in each of the three ambulatory settings.

The services that we have identified for payment rate alignment reflect a core Commission principle: If it is safe and appropriate to provide a service in different settings, Medicare should not pay more for that service in one setting than in another. While we have identified services for which payment rates could be aligned across ambulatory settings, the Congress would need to give CMS the authority to independently make decisions about which services to include in a payment rate alignment policy. In the Commission's analysis, we have largely relied on service volume to identify services for payment rate alignment, but CMS could be further informed by clinicians and other stakeholders through notice-and-comment rulemaking, technical advisory panels, or other processes. Based on this clinical information, CMS could define a list of services for payment rate alignment that may differ somewhat from our example list. CMS also could modify the list of aligned services if the agency concluded that payment rate alignment for any service would result in hospitals reacting in any unintended and undesirable ways.

Though we have chosen to identify services for payment rate alignment based on volume across settings, we caution that the share of a service provided in a particular setting can change over time. For example, as discussed above, the billing of chemotherapy administration has been shifting from freestanding offices to HOPDs in part because of payment policies that encourage hospitals to acquire physician practices (see Table 8-1, p. 358). From 2012 to 2021, the share of chemotherapy administration provided in HOPDs increased from 35 percent to 52 percent, with no apparent change in the types of services provided. Therefore, when using volume as a basis for identifying the setting in which a service is predominantly provided, volume should be evaluated over a number of years and not at a single point in time, and the factors driving changes in volume should be considered carefully.

Setting aligned payment rates

For the 57 APCs for which we aligned payment rates across the three ambulatory settings, we aligned OPPS and ASC system payment rates with PFS payment rates largely on the basis of the differences between nonfacility practice expenses (PEs) and facility PEs from the PFS. Each HCPCS code covered under the PFS has a nonfacility PE and a facility PE. When a service is provided in an office, Medicare makes a single payment to the clinician under the PFS, which includes an amount for PE (the nonfacility PE) intended to cover the cost of the clinical staff, medical equipment, medical supplies, and additional overhead incurred in providing the service. When a service is provided in an HOPD, Medicare makes two payments—one to the clinician under the PFS, which includes an amount for PE (the facility PE) that is lower than the amount for PE in an office, and one to the HOPD under the OPPS to cover the associated costs of the hospital. Though the nonfacility PE paid for an office-based service is higher than the facility PE, in most cases the PFS payment for a service that is provided in a freestanding office is lower than the combined OPPS and PFS payments for a service delivered in an HOPD. To better align these total payment amounts for each of the 57 APCs, we set the OPPS payment for the HOPD equal to the weighted average of the difference between the nonfacility PEs and facility PEs for the HCPCS codes in that APC, where the weights were the total volume of services for each HCPCS code in the APC (see the text box, pp. 364–365, for an example of how we used the nonfacility and facility PEs to align OPPS and ASC payment rates with PFS payment rates). We then added to this weighted average an estimated amount for the additional packaging of ancillary items that are included in the payment rates in the OPPS and ASC payment systems but not the PFS. For a detailed discussion of how we calculated the amount of packaging for each APC, see Chapter 6 in the Commission's June 2022 report to the Congress.

For the nine APCs for which we aligned OPPS payment rates with ASC payment rates, the process for aligning payment rates was straightforward because ASC payment rates are generally based on OPPS payment rates, with comparable relative weights and packaging of ancillary services. For each APC, the aligned payment rate was a weighted average of the ASC payment rates for the HCPCS codes in the APC, where the weights were the volume of services represented in each of the APC's HCPCS codes. Adjustments for packaged ancillary items were not needed because the OPPS and the ASC system have the same method for packaging those items. We made no adjustment to the PFS payment rates for the services in these nine APCs.

Maintaining access to emergency care and hospitals' standby capacity

Our analysis includes 66 APCs for which payment rates could be aligned across ambulatory settings: 57 APCs for which we aligned OPPS and ASC payment rates with PFS payment rates and 9 APCs for which we aligned OPPS payment rates with ASC payment rates.

The alignment of payment rates across ambulatory settings should achieve two goals. One is that, for services that can be safely and appropriately provided to most beneficiaries in more than one ambulatory setting, payment rates should be set such that there is no financial incentive for providers to favor one setting over another. The other goal is to ensure that HOPDs are adequately supported financially so that patients continue to have access to emergency care and hospitals are able to maintain standby capacity. If payment alignment policies are not implemented appropriately, accomplishing one goal could adversely affect the other.

These two goals can sometimes conflict. For example, the services in the 66 APCs for which we examined payment rate alignment are sometimes provided as part of HOPD visits for emergency or trauma care. In these instances, paying hospitals for the services in the 66 APCs at the aligned payment rates could adversely affect hospitals' ability to maintain access to emergency care and standby capacity. Therefore, aligned payment rates for the services in the 66 APCs should be modified when these services are provided as part of emergency or trauma care.

An effective method for ensuring that hospitals are adequately supported for their emergency care and standby capacity is to augment the aligned payment rates when one of the services in the 66 APCs is provided as part of a visit for emergency or trauma care. One way to augment the aligned payment rates

Method for aligning payment rates under the outpatient prospective payment system with payment rates from the physician fee schedule

When a physician provides a service in a freestanding office or a hospital outpatient department (HOPD), the physician's payment under the fee schedule for physicians and other health professionals, also known as the physician fee schedule (PFS), has three components: physician work, practice expense (PE), and professional liability insurance (PLI). The work and PLI payments are the same regardless of setting. However, the PE payment for a service provided in an office (the nonfacility PE) is usually higher than the PE payment for a service provided in an HOPD (the facility PE). The higher nonfacility PE payment reflects the cost of the clinical staff, medical equipment, medical supplies, and additional overhead incurred by physicians. Therefore, the PFS payment is higher in a freestanding office than in an HOPD for most services. However, when a service is provided in an HOPD, Medicare makes an additional payment to the hospital under the outpatient prospective payment system (OPPS). In most cases, the PFS payment for a service that is provided in a freestanding office is lower than the combined OPPS and PFS payments for a service delivered in an HOPD.

For example, in 2023, when an epidural injection into the lumbar or sacral region is provided in a freestanding office, the payment to the physician (the combined physician work, PLI, and nonfacility PE) totals $255.89 (Table 8-4). If the service is provided in an HOPD, the total payment equals the sum of the work, PLI, facility PE, and OPPS payment for a total of $740.88.

In our method for aligning payment rates across ambulatory settings, we adjust the OPPS payment rate for a service to create an equal payment rate across sites of care by setting the OPPS rate equal to the difference between the nonfacility PE rate

(continued next page)

would be to multiply the aligned payment rate by the average percentage by which the aligned payment rates were lowered from their standard OPPS payment rates, then add that result to the aligned payment rate. On average, the aligned payment rates in the 66 APCs are 43 percent of the standard OPPS payment rates. To capture these circumstances in billing, CMS could create modifiers that hospitals would record on claims.

Adjusting for differences in health status is not necessary for an effective system of aligning payment rates

We considered whether aligned payments should be adjusted for differences in patient severity. An analysis sponsored by the American Hospital Association suggests that patients receiving care in HOPDs are more medically complex than those receiving care in freestanding offices (American Hospital Association 2021). However, our analyses show that the effects of patient severity on cost of care for the aligned services is not statistically significant, as the services we selected for alignment were generally of low complexity. In addition, under the OPPS, providers can often bill separately for additional services that a patient might need.

To make this assessment, we evaluated risk scores from the CMS hierarchical condition category (CMS–HCC) risk-adjustment model to compare the medical complexity of HOPD patients with patients in freestanding offices. We found that, on average, HOPD patients have higher risk scores, which suggests that HOPD patients are potentially more medically complex than those in physician offices. However, we also found substantial overlap in the CMS–HCC risk scores of patients in these two settings, which suggests that the difference in patient severity between settings is small. For example, among the 57 APCs for which we aligned OPPS payment rates with PFS payment rates, we combined the risk scores from the 57 APCs for the

Method for aligning payment rates under the outpatient prospective payment system with payment rates from the physician fee schedule (cont.)

TABLE 8–4 **Differences in payment rates for epidural injection into the lumbar or sacral regions in physician's office or HOPD, 2023**

Actual 2023 payment rates		Policy that would align rates across settings	
Service in physician's office		***Service in physician's office***	
Physician work	$59.51	Physician work	$59.51
Nonfacility PE	$190.43	Nonfacility PE	$190.43
Professional liability insurance	+ $5.95	Professional liability insurance	+ $5.95
Total payment	**$255.89**	**Total payment**	**$255.89**
Service in HOPD		***Service in HOPD***	
Physician work	$59.51	Physician work	$59.51
Facility PE	$31.08	Facility PE	$31.08
Professional liability insurance	+ $5.95	Professional liability insurance	+ $5.95
Payment to physician	$96.54	Payment to physician	$96.54
Payment to HOPD (OPPS rate)	+ $644.34	Payment to HOPD (nonfacility PE – facility PE)	+ $159.35
Total payment	**$740.88**	**Total payment**	**$255.89**

Note: HOPD (hospital outpatient department), PE (practice expense), OPPS (outpatient prospective payment system). Payments include both program spending and beneficiary cost sharing. The payment rates in this table are those for Current Procedural Terminology code 62323.

Source: MedPAC analysis of physician fee schedule and OPPS payment rates for 2023.

and facility PE rate. For this epidural procedure, the nonfacility PE is $190.43 and the facility PE is $31.08. The difference between these two amounts produces an adjusted OPPS rate of $159.35. With this adjustment, the total payment Medicare would make when this procedure is provided in an HOPD would fall to $255.89, which is the same as if paid in a freestanding office. We made an additional adjustment to the aligned payment rate of $255.89 to account for the additional packaging of ancillary items in the OPPS that does not occur in the PFS. We estimated that packaged ancillary items added 23.5 percent to the HOPD cost of providing this service. Therefore, the final aligned payment rate for this service was $255.89 × 1.235 = $316.02 (not shown in Table 8-4). ■

HOPD patients with the risk scores for patients in freestanding offices. We found that just 8 percent of the risk scores for HOPD patients were above the 95th percentile of that combined distribution.

Moreover, a difference in patient severity between settings does not necessarily mean that provision of the services included in our analysis is more costly for sicker patients since most of these services are low complexity. The uncertainty over whether it would be beneficial to adjust aligned payment rates for differences in patient severity led us to use regression analysis to evaluate the extent to which hospital charges are affected by patient severity in the 66 APCs

for which we aligned payment rates.[2] Results from this regression analysis indicated that patient health status has an insignificant effect on hospital charges for the services in the 66 APCs (Medicare Payment Advisory Commission 2022). Consequently, we conclude that adjustments for patient severity are not necessary for the services in the 66 APCs in our analysis.

The insignificant effect of patient health status on hospital charges is likely due to a combination of factors, including:

- The services in the 66 APCs are generally low-complexity services that are unlikely to require additional resources if the patient is in poor health. The average OPPS relative weight (a measure of the resources needed to furnish a service in HOPDs) for the services in the 66 APCs is 1.9, while the average relative weight for all services covered under the OPPS is 5.0.
- If a patient requires additional resources because of health status, the structure of the OPPS often allows the provider to bill separately for any additional services that are needed. This structure of the OPPS contrasts with the inpatient prospective payment systems, under which providers generally are not allowed to bill separately for additional services.

Effect of aligning payment rates across three ambulatory settings

We estimate that aligning payment rates across the ambulatory settings would have reduced Medicare OPPS outlays for the 66 APCs in 2021 by $6.0 billion and beneficiary cost sharing by $1.5 billion. But because current law would require the payment rate changes to be implemented on a budget-neutral basis, payment alignment would have been accompanied by an increase in the payment rates for the remaining 103 APCs for which we determined that payment rate alignment was not appropriate. This budget-neutrality adjustment would have left aggregate OPPS spending unchanged in 2021. Over time, however, aligning payment rates for select services would improve financial incentives under the OPPS, making it less financially advantageous for hospitals to acquire physician practices and bill for their services under the usually higher-paying OPPS. Such a result would produce budgetary savings.

The impacts of payment alignment would differ across hospitals, with some seeing overall losses in OPPS revenue because they provide a disproportionately high share of the low-complexity site-neutral services relative to other hospitals. In contrast, other hospitals would see a rise in revenue because they provide a disproportionately high share of the more complex services for which payment rates would increase under the budget-neutrality adjustment. The Commission asserts that concerns about specific types of hospitals being adversely affected due to payment alignment should be addressed through targeted assistance to those hospitals rather than paying all hospitals higher-than-warranted rates for certain services.

Effects of aligning OPPS and ASC payment rates for specified services with PFS payment rates

For the 57 APCs for which we aligned payment rates across the three ambulatory settings, we modeled the pecuniary effects of payment rate alignment for a single year, 2021, and did not model a transition or behavioral changes on the part of providers.

In aggregate, in a scenario in which lower payments for site-neutral services would be retained as Medicare savings, aligning the OPPS payment rates with PFS payment rates for the 57 APCs would have reduced Medicare OPPS outlays on the included services in 2021 by $4.9 billion and beneficiary cost-sharing obligations by $1.2 billion, for a total impact of $6.2 billion. For all OPPS hospitals (the OPPS excludes critical access hospitals and Maryland hospitals), the reduced payments for these services represents 3.2 percent of hospitals' total Medicare revenue (Medicare revenue for all service lines, which includes inpatient, outpatient, and post-acute care).

However, as noted above, under current law, CMS would apply an upward pro rata adjustment to the payment rates for the 103 APCs for which we have determined that payment rate alignment is not appropriate. This adjustment would fully offset the lower hospital revenue from the payment rate alignment, producing a budget-neutral result under the assumption that the volume of services billed under the

OPPS does not change from the most recent year for which CMS has OPPS volume data, which is usually two years prior to the current year. In practice, payment rate alignment would likely produce lower beneficiary cost sharing and program outlays immediately because of the trend to shift the billing of services from the PFS to the OPPS.[3]

In addition, aligning the ASC payment rates with the PFS payment rates for the 57 APCs in 2021 would have reduced Medicare outlays on these services under the ASC payment system by $200 million and beneficiary cost-sharing liability by $50 million. This reduction in Medicare payments and cost sharing on these services represents 4.3 percent of aggregate ASC Medicare revenue. CMS would apply a budget-neutral adjustment to the other services in the ASC payment system to offset the effects of the payment rate alignment.

Effects of aligning OPPS payment rates for specified services with ASC payment rates

We also modeled the effects of aligning payment rates for the nine APCs for which OPPS payment rates could be based on ASC payment rates. We estimated that combined Medicare payments and beneficiary cost sharing on the services in these APCs would have fallen by $1.3 billion in 2021 (a decrease of $1.0 billion in program payments and $0.3 billion in beneficiary cost-sharing liability), assuming no budget-neutrality adjustment and no change in HOPD volume. For all OPPS hospitals, the reduced spending on these services of $1.3 billion represents 0.6 percent of hospitals' total Medicare revenue.

A potential problem with aligning OPPS payment rates with ASC payments is that the number of ASCs per capita varies considerably by geographic region. Some states have far more ASCs per capita than others. For example, Maryland has about 38 ASCs per 100,000 Part B Medicare beneficiaries, while Vermont has 1.5. Also, ASCs are much more heavily concentrated in urban areas than in rural areas (Medicare Payment Advisory Commission 2023). In contrast to ASCs, hospitals are more evenly distributed across geographic areas. If hospitals reduce the provision of the services in these nine APCs in response to payment rate alignment, access to these services could become difficult in areas that lack ASC presence. Therefore, CMS might consider an upward adjustment to OPPS payment rates that are aligned with ASC payment rates if the hospital is located in an area that lacks the presence of ASCs.

Financial effects on providers of aligning OPPS payment rates

We estimate that aligning payment rates across the ambulatory settings for the 66 APCs would have reduced Medicare OPPS outlays in 2021 by $6.0 billion and beneficiary cost sharing by $1.5 billion, for a total reduction of $7.5 billion (assuming lower payment rates were retained by Medicare as program savings), or 3.8 percent of aggregate Medicare revenue for OPPS hospitals. However, as noted earlier, under current law (Section 1833(t)(9)(B) of the Social Security Act), the reduced program spending and beneficiary cost sharing would not be taken as savings, but instead would be fully offset through higher payment rates in the OPPS for the 103 APCs for which we would not align payment rates.[4]

Although under budgetary accounting rules the budget-neutral adjustment would leave no immediate savings, per se, in program spending and beneficiary cost sharing, program spending and beneficiary cost sharing would eventually decline because incentives for providers in higher-cost settings to acquire providers in lower-cost settings would be diminished. By contrast, payment rates for emergency and trauma care visits would be increased as part of the budget-neutrality adjustment, which would help maintain hospitals' emergency departments and standby capacity.

Even though the payment rate alignment policy combined with the current-law budget-neutrality adjustment would have no immediate effect on total Medicare revenue for OPPS hospitals in aggregate, some types of hospitals would see an immediate increase in total Medicare revenue while others would face a decline. Some hospitals would see a decline in revenue because they provide a disproportionately high share of the low-complexity site-neutral services relative to other hospitals. In contrast, other hospitals would see a rise in revenue because they provide a disproportionately high share of the more complex services that would have their payment rates increase under the budget-neutrality adjustment.

Rural hospitals would face the greatest loss in total Medicare revenue under a budget-neutral,

redistributive site-neutral payment policy—a 2.5 percent loss (Table 8-5). Some stakeholders could be concerned that this loss in revenue for rural hospitals would adversely affect access to care for rural beneficiaries. For the following reasons, we do not believe that this drop in Medicare revenue would have a substantial adverse effect on rural beneficiaries:

- Rural hospitals have better financial performance than urban hospitals under Medicare FFS payment systems (Medicare Payment Advisory Commission 2023).
- Rural hospitals benefit more than other hospital categories from the Commission's policy on safety-net hospitals (Medicare Payment Advisory Commission 2023).
- Critical access hospitals are not paid under the OPPS, so they would be unaffected by payment rate alignment.
- OPPS payment rates for services provided in rural sole community hospitals are 7.1 percent higher than standard OPPS payment rates. This adjustment would apply to the aligned payment rates for the 66 APCs.

Some have cautioned that lower OPPS payment rates for services in aligned APCs could adversely affect access in the HOPD setting for complex, high-cost patients. This access would be somewhat mitigated by the OPPS outlier policy, which provides additional OPPS payments when hospitals incur costs for providing a service that substantially exceed the OPPS payment rate for that service.

Aligning payment rates for selected ambulatory services would improve financial incentives

The payment rate alignment policy presented in this chapter reflects the principle that if the same service can be safely provided in different settings, Medicare should not pay more for that service in one setting than in another. The Commission supports a payment alignment policy based on clinical input and examination of existing utilization patterns. Irrespective of the services included in a payment rate alignment policy, such a policy would reduce incentives for hospitals to consolidate with providers in lower-cost settings, which would eventually result in lower Medicare program spending and beneficiary cost-sharing obligations.

RECOMMENDATION 8

The Congress should more closely align payment rates across ambulatory settings for selected services that are safe and appropriate to provide in all settings and when doing so does not pose a risk to access.

We emphasize that CMS should make the final decision concerning the services for which it is appropriate to align OPPS payment rates with either PFS rates or ASC rates. In aligning payments across settings, CMS should determine that the service is safe and appropriate to provide in ambulatory settings outside of HOPDs in the majority of circumstances. In addition, CMS should include only services that would not result in hospitals reducing beneficiaries' access to care or acting in other unintended and undesirable ways.

CMS should also ensure that payment rate alignment does not adversely affect hospitals' ability to maintain emergency care and standby capacity. The budget-neutral adjustment that CMS would make to the nonaligned services would support emergency care and standby capacity by raising OPPS payment rates for ED visits. To provide further support, CMS could augment the aligned payment rates when one of the aligned services is provided as part of a visit for emergency care. Finally, CMS should closely monitor the effect that payment rate alignment has on beneficiary access to the services that have aligned payment rates.

RATIONALE 8

The current FFS payment rates in ambulatory settings are generally higher for services provided in HOPDs than for services provided in ASCs and freestanding offices, even for services that can be safely provided to most beneficiaries in all three settings. These payment rate differences give hospitals an incentive to acquire physician practices and start billing for the same services as outpatient services. This change in billing leads to higher Medicare program spending and beneficiary cost-sharing obligations without significant changes to patient care.

TABLE 8–5

Changes in Medicare revenue from aligning OPPS payment rates with PFS payment rates for select ambulatory services, assuming budget-neutral adjustment for other OPPS services

Category	Percent change in total Medicare revenue
All hospitals	0.0%
Urban	0.2
Rural (excludes critical access hospitals)	–2.5
Nonprofit	0.0
For profit	1.0
Government	–0.8
Major teaching	–0.6
Other teaching	0.5
Nonteaching	0.1
DSH patient percentage	
Below median	0.3
Above median	–0.3
Number of beds	
Less than 50	–2.3
50–100	–1.7
101–250	0.1
251–500	0.4
More than 500	0.1

Note: OPPS (outpatient prospective payment system), PFS (physician fee schedule), DSH (disproportionate share hospital).

Source: MedPAC analysis of data from hospital cost reports and standard analytic claims files, 2021.

IMPLICATIONS 8

Spending

- This recommendation would have no direct effect on Medicare program spending because CMS would apply budget-neutral increases to the OPPS payment rates of the nonaligned services to offset the effects of the lower aligned payment rates. However, this recommendation could have an indirect effect on program spending, as it would reduce incentives for hospitals to acquire physician practices, which would lower the extent to which the billing of the services with aligned payment rates shifts from the PFS to the OPPS. We cannot be certain of the magnitude of the program savings because we are not certain of the extent to which this policy would mitigate hospital acquisition of physician practices. However, the magnitude of the program savings would rise over time if provider consolidation slowed as a result of the changes to Medicare payments to hospital outpatient departments and ambulatory surgical centers, should this recommendation be adopted.

Beneficiary and provider

- *Beneficiaries*: Beneficiaries would incur lower cost-sharing liability for site-neutral services, and we expect that they would continue to have access to

the services included in the aligned payment rates. In the short term, aggregate beneficiary cost-sharing liability would be unchanged.

- *Providers*: In aggregate, we do not expect this recommendation to have an adverse effect on providers' willingness or ability to furnish ambulatory services. However, the recommendation would raise total Medicare revenue for some hospital categories and lower it for others. Concerns about specific types of hospitals being adversely affected by payment rate alignment should be addressed with targeted assistance to those hospitals rather than inefficiently supporting them by maintaining higher payment rates for site-neutral services for all hospitals. ■

Endnotes

1 The OPPS also has 579 APCs for drugs, devices, blood products, and brachytherapy sources.

2 It would have been preferable to use hospital costs rather than hospital charges, as the extent to which hospitals mark up charges above costs varies by hospital. However, we adjusted for variation in hospital markup by including a fixed-effects indicator for each hospital in our regression analysis.

3 When CMS sets OPPS payment rates, the agency uses the most recent data on service volume to make any required budget-neutrality adjustments. Typically, these data are from two years prior to the year for which the agency is setting payment rates. For example, when CMS set OPPS payment rates for 2023, the agency used volume data from 2021 to make the required budget-neutrality adjustments for 2023. For the services in the 66 APCs that we have identified for payment rate alignment, there is a general trend of these services shifting from the PFS to the OPPS. Since these services have been an increasingly larger share of OPPS volume each year, the volume for these services that CMS would use to make budget-neutrality adjustments in response to payment rate alignment likely would be lower than the volume of services when the aligned payment rates were actually implemented. Therefore, aggregate OPPS spending likely would be lower than what would have been spent without the payment rate alignment.

4 Payment rates for separately payable drugs, pass-through devices, and new-technology APCs would not be affected by the budget-neutral adjustment.

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