

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 3-A-14

Subject: Medicare Update Formulas across Outpatient Sites of Service
(Resolution 112-A-13)

Presented by: Charles F. Willson, MD, Chair

Referred to: Reference Committee A
(Gary L. Bryant, MD, Chair)

1 At the 2013 Annual Meeting, the House of Delegates referred Resolution 112, “Unfair Medicare
2 Payment Practice,” which was introduced by the Florida Delegation. Resolution 112-A-13 asked:

3
4 That our American Medical Association (AMA) seek legislation to fairly compensate
5 procedures across all service sites (physician office, ambulatory surgical centers and hospital
6 outpatient departments) to include a single formula for reimbursement that recognizes the
7 different average resource costs to provide each procedure and a single update formula (such as
8 the Consumer Price Index for all Urban Consumers) for all sites with an appropriate conversion
9 factor that recognizes different average resource costs for the different sites.

10
11 This report provides background on Medicare update formulas; describes growth in the share of
12 outpatient procedures provided by hospitals; highlights AMA advocacy efforts; summarizes
13 relevant AMA policy; and presents policy recommendations.

14
15 **BACKGROUND**

16
17 Many outpatient procedures can be safely provided in multiple settings—including physician
18 offices, ambulatory surgical centers (ASCs) and hospital outpatient departments (HOPDs)—without
19 impacting patient care or outcomes. However, Medicare payments and patient cost-sharing vary
20 substantially by service site. Generally speaking, outpatient procedures performed in HOPDs are
21 more costly to the Medicare program, and to patients in terms of cost-sharing, than services
22 furnished in physician offices or ASCs. A comparison of Medicare payments for procedures
23 performed across multiple outpatient settings was included in Council on Medical Service Report
24 3-A-13.

25
26 The variance in Medicare and patient financial liability across service sites stems from the use of
27 separate methodologies to calculate payment rates for physician offices, ASCs and HOPDs.
28 Formulas unique to each payment system are then used to annually adjust these rates for inflation.
29 For services furnished in physician offices, Medicare pays for units of service billed under the
30 physician fee schedule (PFS). For procedures provided in HOPDs and ASCs, Medicare pays a
31 reduced physician fee under the PFS plus a facility fee established under the hospital outpatient
32 prospective payment system (OPPS). Services paid under the OPPS and the ASC payment systems
33 are classified into several hundred ambulatory payment classifications based on clinical and cost
34 similarities. Surgeries in ASCs are paid at a percentage of the OPPS. For most ambulatory services
35 performed in 2014, Medicare payments to HOPDs are 81 percent higher than rates paid to ASCs.¹

1 Stated another way, payment rates in ASCs are only 55.2 percent of payment rates in HOPDs–
 2 down from 65 percent in 2008.²

3
 4 The gap between payments to HOPDs and ASCs has widened over the years because the update
 5 formulas used by the Centers for Medicare & Medicaid Services (CMS) to annually adjust payment
 6 rates are based on different measures of inflation. OPPS payment increases are based on the
 7 hospital market basket, whereas the formula for updating ASC payment rates uses the Consumer
 8 Price Index for All Urban Consumers (CPI-U). The Medicare Economic Index (MEI) is the price
 9 index used to update physician payments under the PFS; however, under current law, the
 10 Sustainable Growth Rate (SGR) adjustment is applied to the PFS.

Table 1: Inflationary Measures Used to Annually Update PFS, OPPS and ASC Payment Rates

Medicare Economic Index	Hospital Market Basket	Consumer Price Index for All Urban Consumers
Physicians' own time	Compensation	Housing
Non-physician compensation	Utilities	Food
Office expenses	Prof. liability insurance	Apparel
Prof. liability insurance	Other products & services	Transportation
Medical equipment		Medical care
Pharmaceuticals & supplies		Recreation
Other expenses		Education & communication

11 MEI: Together with the SGR, the MEI determines the conversion factor by which payments under
 12 the PFS are calculated. Within the MEI, medical practice resources are categorized as physicians'
 13 own time or physicians' practice expenses. The latter includes subcategories of expenses for office
 14 space, medical equipment, medical supplies, prescription drugs and professional liability insurance.
 15 Year-to-year price changes for resources within expense categories are used to calculate the MEI.

16
 17 CPI-U: CMS has used the CPI-U to update the ASC payment system since Medicare began paying
 18 ASCs to perform surgical procedures in 1982. Calculated by the Bureau of Labor Statistics, the
 19 CPI-U measures change over time in the prices paid by urban consumers for a market basket of
 20 goods and services, including food, apparel, transportation, medical care, recreation, education and
 21 communication, and is highly weighted for housing. Weights are based on spending for each item
 22 by a sample of urban consumers.

23
 24 Hospital market basket: The hospital market basket measures changes in hospital inpatient
 25 operating costs and is used to update both the OPPS and the Inpatient Prospective Payment System.
 26 Weights for categories such as employee compensation, utilities, professional liability insurance
 27 and other products and services within the hospital market basket are produced by the Office of the
 28 Actuary at CMS using Medicare cost reports.

29
 30 Many stakeholders have questioned the use of CPI-U projections to calculate ASC payment
 31 updates because the costs of providing services in a surgical center differ substantially from urban
 32 household expenses captured by the CPI-U. After the Medicare Payment Advisory Commission
 33 (MedPAC) looked at differences in the cost structures between ASCs and other outpatient settings,
 34 it concluded that, in comparison to hospitals and physician offices, a greater share of ASC expenses
 35 was associated with medical supplies and pharmaceuticals.³ MedPAC also reported that, over a ten
 36 year period, growth in the hospital market basket was much higher than the CPI-U.⁴ Overall, the
 37 CPI-U was also found to be a less stable measure of inflation.

1 GROWTH IN THE VOLUME OF OUTPATIENT SERVICES PROVIDED BY HOSPITALS

2
3 Differences in payment rates across outpatient sites have contributed to growth in the volume of
4 outpatient services provided by hospitals, even when these services that can be safely performed in
5 lower-cost settings.⁵ Higher payments to HOPDs have also incentivized the sale of physician
6 practices and ASCs to hospitals. These acquired facilities can be granted provider-based status if
7 they are located within 35 miles of the hospital campus; operate under the main provider's license
8 (unless a separate license is required by the state); are financially integrated with the main provider;
9 and meet the other requirements outlined at 42 CFR § 413.65. Provider-based facilities, including
10 those off campus, are paid the same rate for outpatient services as hospitals.

11
12 Although off-campus, provider-based facilities are required to notify patients that they are being
13 served by the hospital and will be billed accordingly, patients may be unaware of the impact that
14 these distinctions have on the price of procedures as well as their cost-sharing responsibilities.
15 Patients receiving care in a provider-based facility—which may appear on the outside to be a
16 freestanding physician office—are responsible for coinsurance for both the physician payment and a
17 facility fee, whereas patients served in physician offices generally pay only one bill.

18
19 AMA ADVOCACY

20
21 Federal legislation intended to help stabilize payment rates for ASCs by updating their inflationary
22 adjustment with the same market basket used to update HOPDs has been introduced in both houses
23 of Congress. The Ambulatory Surgical Center Quality and Access Act (S. 1137; H.R. 2500) would
24 require annual updates under the ASC payment system to equal OPPI updates. Reporting of
25 quality measures by ASCs and HOPDs would also be revised under the proposed legislation so that
26 side-by-side comparisons of Medicare payment and patient cost-sharing amounts for outpatient
27 procedures would be available on the Medicare website.

28
29 The ASC industry and the AMA have repeatedly urged CMS to adopt the hospital market basket to
30 update the ASC payment system in place of the CPI-U, which measures inflation in a basket of
31 consumer goods atypical of ASC expenses. CMS, however, argues that the hospital market basket
32 is not reflective of the cost structures of ASCs and, in the absence of a replacement formula, CMS
33 continues to use the CPI-U.⁶

34
35 RELEVANT AMA POLICY

36
37 The AMA strongly supports equitable Medicare payments across outpatient sites of service. Policy
38 H-330.925 encourages CMS to fairly pay physicians for office-based procedures; adopt a single
39 facility payment schedule for HOPDs and ASCs; and use valid and reliable data to develop
40 payment methodologies for the provision of ambulatory services. The same policy directs the
41 AMA to join other interested organizations to lobby for any needed changes to regulations
42 affecting payments to ASCs to assure a fair rate of payment.

43
44 AMA policy also supports defining Medicare services consistently across settings, encouraging
45 CMS to adopt payment methodologies that assist in leveling the playing field across all sites of
46 service and consider seeking a legislative remedy to the payment disparities between HOPDs and
47 ASCs (Policy D-330.997). Policy H-240.993 further supports equity of payment between services
48 provided in the HOPD and similar services furnished in physician offices.

49
50 Policy D-240.994 directs the AMA to work with states to advocate that third-party payers be
51 required to: assess equal or lower facility coinsurance for lower-cost sites of service; publish and

1 routinely update pertinent information related to patient cost-sharing; and allow their plan's
2 participating physicians to perform outpatient procedures at an appropriate site of service as chosen
3 by the physician and the patient. Furthermore, AMA policy urges private third-party payers to
4 implement coverage policies that do not unfairly discriminate between hospital-owned and
5 independently owned outpatient facilities with respect to payment of "facility" costs (Policy
6 H-240.979).

7
8 Policy H-400.966 directs the AMA to aggressively promote the compilation of accurate data on all
9 components of physician practice costs, and the changes in such costs over time, as the basis for
10 informed and effective advocacy concerning physician payment under Medicare. The same policy
11 directs the AMA to work with CMS, the Bureau of Labor Statistics and other appropriate federal
12 agencies to improve the accuracy of such indices of market activity as the MEI and the medical
13 component of the Consumer Price Index.

14 15 DISCUSSION

16
17 The Council believes that existing Medicare payment formulas have contributed to the migration of
18 outpatient care to hospitals and hospital-owned facilities. Payments to physician offices, adjusted
19 annually by the SGR, have been stagnant for years. Payment rates to ASCs have been similarly
20 sluggish. The AMA has extensive policy calling for fair and equitable Medicare payments for
21 procedures performed across outpatient settings. Accordingly, the Council believes the AMA
22 should reaffirm Policies H-400.957, D-330.997 and H-400.966.

23
24 The Council further believes that CMS should annually adjust payments for outpatient services
25 using update factors that are based on the same inflationary measure. The Council discussed the
26 development of a new outpatient market basket but, acknowledging the complexity involved in this
27 endeavor, does not make a recommendation.

28
29 Instead, the Council concludes that the hospital market basket better reflects changes in ASC costs
30 than the CPI-U. Absent an outpatient market basket, the Council recommends that CMS use the
31 hospital market basket index to annually update ASC payment rates. The Council recommends
32 modifying Policy H-330.925 to incorporate this recommendation, and to delete policy that is no
33 longer relevant because many outpatient services are packaged under the OPPTS into ambulatory
34 payment classifications.

35
36 The Council has concerns about the increase in hospital acquisitions of freestanding physician
37 offices and ASCs, and the high cost of treating these facilities as HOPDs. Of particular concern are
38 Medicare patients who incur higher cost-sharing expenses for HOPD-billed services provided away
39 from the hospital campus. These patients may reasonably assume they are receiving services at
40 physician office rates and be taken aback by substantially higher charges and cost-sharing amounts.
41 The Council will consider policy options related to these trends in a future report on provider-based
42 billing. In the interim, the Council recommends encouraging CMS to begin collecting data on the
43 frequency, type and cost of services furnished in off-campus, provider-based departments.

44 45 RECOMMENDATIONS

46
47 The Council recommends that the following be adopted in lieu of Resolution 112-A-13, and that
48 the remainder of the report be filed:

- 49
50 1. That our American Medical Association reaffirm Policy H-400.957, which encourages the
51 Centers for Medicare & Medicaid Services (CMS) to expand the extent and amount of

- 1 payment for procedures performed in physician offices, shift more procedures to the less
2 costly office setting, and seek to have the RBRVS practice expense RVUs reflect the true
3 cost of performing office procedures. (Reaffirm HOD Policy)
4
- 5 2. That our AMA reaffirm Policy D-330.997, which encourages the CMS to define Medicare
6 services consistently across settings and adopt a payment methodology that will assist in
7 leveling the playing field across all sites of service. (Reaffirm HOD Policy)
8
- 9 3. That our AMA reaffirm Policy H-400.966, which directs the AMA to promote the
10 compilation of accurate data on physician practice costs and changes to those costs over
11 time as the basis of Medicare payment advocacy. (Reaffirm HOD Policy)
12
- 13 4. That our AMA amend Policy H-330.925 by insertion and deletion as follows:
14
- 15 H-330.925 Appropriate Payment Level Differences by Place and Type of Service
16 Our AMA (1) encourages CMS to adopt policy and establish mechanisms to fairly
17 reimburse physicians for office-based procedures; (2) encourages CMS to adopt a ~~single~~
18 ~~facility payment schedule~~ site neutral payment policy for hospital outpatient departments
19 and ambulatory surgical centers; (3) advocates for the use of valid and reliable data in the
20 development of any payment methodology for the provision of ambulatory services; (4)
21 advocates that in place of the Consumer Price Index for all Urban Consumers (CPI-U),
22 CMS use the hospital market basket index to annually update ambulatory surgical center
23 payment rates; ~~(4) continues to oppose the implementation of any prospectively determined~~
24 ~~classification and payment system for Medicare ambulatory services that is based upon a~~
25 ~~methodology that bundles or groups services;~~ ~~(5) advocates for payments for hospital~~
26 ~~outpatient department services and ambulatory surgical services that are based on~~
27 ~~individual services;~~ (6) encourages the use of CPT codes across all sites-of-service as the
28 only acceptable approach to payment methodology; and ~~(7)~~ will join other interested
29 organizations and lobby for any needed changes in existing and proposed regulations
30 affecting payment for ambulatory surgical centers to assure a fair rate of reimbursement for
31 ambulatory surgery. (Modify HOD Policy)
32
- 33 5. That our AMA continue to encourage the CMS to collect data on the frequency, type and
34 cost of services furnished in off-campus, provider-based departments. (Directive to Take
35 Action)

Fiscal Note: Less than \$500

REFERENCES

¹ Report to the Congress: Medicare Payment Policy. Medicare Payment Advisory Committee (MedPAC). March 2014.

² Ibid.

³ Report to the Congress: Medicare Payment Policy. Medicare Payment Advisory Committee (MedPAC). March 2010.

⁴ Ibid.

⁵ Report to the Congress: Medicare Payment Policy. Medicare Payment Advisory Committee (MedPAC). March 2013.

⁶ Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Hospital Value-Based Purchasing Program; Organ Procurement Organizations; Quality Improvement Organizations; Electronic Health Records (EHR) Incentive Program; Provider Reimbursement Determinations and Appeals. Department of Health and Human Services, Centers for Medicare & Medicaid Services. Federal Register, vol. 78: 75088-75089. December 10, 2014.