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Changes in Health Care Financing & Organization (HCFO)

findings brief

key findings

- Medicare OPPS-induced rate reduction was associated with a reduction or no change in Medicare volume, depending on the service and an increase in private FFS outpatient hospital volume.
- Hospitals with higher exposure to Medicare generated greater increased in private FFS volume and smaller decreases in Medicare volume.

Florida Hospitals' Volume Response to Medicare's Outpatient Prospective Payment System

Background

The Medicare Outpatient Prospective Payment System (OPPS) was established by the Balanced Budget Act of 1997 and went into effect on August 1, 2000. The OPPS was an attempt to simplify and reduce Medicare payments for hospital outpatient services by creating a new fee schedule. Before the advent of OPPS, Medicare payments for outpatient services were largely based on a hospital's actual costs and therefore provided little incentive for hospitals to find lower-cost approaches to service delivery. The OPPS fee schedule combines procedures, based on clinical and cost similarity, into groups called Ambulatory Payment Classifications (APC), sets a payment rate that applies to services in the APC group, and makes adjustments where necessary. The predetermined payments help provide hospitals with an incentive to lower the costs of health care delivery.

In a Robert Wood Johnson Foundation's Changes in Health Care Financing and Organization (HCFO) program-funded study, Daifeng He, Ph.D., and Jennifer Mellor, Ph.D., studied the effects of the OPPS on how much outpatient care is provided by Florida hospitals and who pays for it. The results of the study were published in the September 2012 issue of the *Journal of Health Economics*.[1] The researchers examined the effect of OPPS-induced payment changes on the volume of hospital outpatient services provided both to Medicare patients and patients covered by commercial insurance.

"The ability of the OPPS to contain costs depends on how volume responds. One possibility is that lowering payments actually increases the number of services provided. This might happen if outpatient departments try to make up for revenues lost from payment cuts by providing more care. Not only might more care be provided to Medicare patients, but more services might be provided to patients covered by commercial insurance as well. And, especially if both of these are happening, the cost containment goals of the policy could be threatened," says Mellor.

Robert Wood Johnson Foundation

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Data and Methods

He and Mellor used a data set derived from the ambulatory discharge records of short-term general hospitals in Florida over the period 1997 through 2008. They argue that the Florida data are likely to be representative of the Medicare population as a whole in that Florida is the fourth most populous state in the United States, accounts for a large number of hospitals, reports the second-highest state Medicare spending, and represents 8 percent of Medicare spending nationwide.

The researchers used discharge records to construct hospital- and procedure-specific counts of the 10 most common hospital outpatient surgical procedures. To gather the reimbursement rates for each hospital, procedure, and year in the years after the OPPS went into effect, the researchers obtained quarterly Centers for Medicare and Medicaid Services (CMS) publications that reported payments for each ambulatory payment classification (APC). The researchers created an algorithm to identify procedure-specific charges and converted them to actual payments for each hospital and procedure of interest during the pre–OPPS years.

To determine how volume changed at different types of hospitals, the researchers gathered data on hospital-physician integration and Medicare share at baseline. They hypothesized that hospitals with closer relationships with physicians would be more successful in increasing volume in response to payment rate cuts and that hospitals with greater exposure to Medicare would be more motivated to increase volume when payment rates fall. The researchers determined exposure to Medicare by the total number of outpatient surgeries in facilities where the primary payer was fee-for-service (FFS) Medicare. The study gathered information on hospital-physician integration from the American Hospital Association's Annual Survey of Hospitals.

To analyze the data, the researchers estimated three statistical models. The first model tested how the volume of outpatient surgeries responded to the OPPS-induced Medicare payment changes. The second model evaluated how the response varied by Medicare exposure. The third model evaluated how the response varied across hospitals that were and were not integrated with physicians.

Results

For the average hospital, the analyses show that Medicare payment rate cuts associated with the adoption of outpatient prospective payment either reduced or produced no statistically significant change on Medicare volume, depending on the service. In addition, private non–Medicare FFS volume increased in response to OPPS-induced rate cuts. Through the use of a falsification test, the researchers showed that the volume changes resulted from the implementation of OPPS and were not simply an artifact of trends in volume that were occurring regardless of the new payment policy.

Evaluation of how the effects varied by Medicare exposure found that highly exposed hospitals (i.e., those with a higher percentage of outpatient surgeries paid for by FFS Medicare) responded to payment cuts differently than did hospitals with less Medicare exposure (i.e., those with a lower percentage of outpatient surgeries paid for by FFS Medicare). Hospitals with greater exposure to Medicare responded with smaller decreases in Medicare volume and, in some cases, with increases in Medicare volume. They also responded with larger increases in commercial FFS volume.

When examining how the effects varied by physician-hospital integration, the researchers found evidence of a greater volume increase for both Medicare and private non–Medicare FFS in vertically integrated hospital systems than in non-integrated hospitals. The researchers explain that physicians with formal affiliations with hospitals may be more concerned with hospital profit and thus more likely to provide additional patient services when hospital payment rates are cut. However, the researchers caution that the findings are only suggestive; only a few interactions were statistically significant.

Policy Discussion

As policymakers continue to look for ways to reduce health care costs and spending, many reform efforts have attempted to work within the current FFS-based system. The Medicare OPPS represents one attempt to reform Medicare while preserving the current payment system. The study findings suggest that savings from reducing the cost of outpatient procedures could be offset by increased volume. For a true reduction in costs, however, reforms may need to move away from an FFS-based system.

To bend the cost curve, the authors recommend that Medicare shift from an FFS system and consider alternative provider payment structures. The Patient Protection and Affordable Care Act (ACA) includes provisions for a number of such alternative models, including bundled payments and patient-centered medical homes. According to He and Mellor's findings, the alternative models, though still in need of further research and testing, are less likely to increase volume.

In addition, findings on the impact of hospital-physician integration are useful as the vertical integration of physicians and hospitals continues. Particularly of interest are Accountable Care Organizations (ACO), which are groups of doctors, hospitals, and other health care providers that provide coordinated care to Medicare patients.[2] If an ACO succeeds in reducing spending while maintaining quality, participating providers share in the savings achieved for the Medicare program. However, He and Mellor's findings caution that vertically integrated provider systems may respond to rate changes by increasing volume. In fact, their findings could be used to inform

the effective development of ACOs. "The results of this study are particularly worrisome for overall cost containment—that is, both Medicare and private costs combined—through fee cuts. They suggest that reductions in fee-for-service payments for Medicare patients have the spillover effect of increasing the amount of care paid for by private insurers," says He.

Conclusion

Changes in fees and reimbursement rates alone cannot be guaranteed to bend the cost curve. He and Mellor's findings underscore the importance of researching and evaluating the unintended consequences of policy changes. As the study demonstrates, a change in reimbursement rates in Medicare can have spillover effects on non–Medicare utilization. It is important for researchers and policymakers to examine and consider such potential effects.

For More Information

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Endnotes

1 For complete findings, see He D. and J. Mellor. "Hospital Volume Responses to Medicare's Outpatient Prospective Payment System: Evidence from Florida." *Journal of Health Economics*, Vol. 31, No. 5, September 2012, pp. 730-43.

2 See more at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html?redirect=/aco/.