CHAPTER 2

Updating payments for physician services and for care provided in hospital outpatient departments

RECOMMENDATIONS

2A The Congress should replace the sustainable growth rate system with an annual update based on factors influencing the unit costs of efficiently providing physician services.

***YES: 14 • NO: 0 • NOT VOTING: 0 • ABSENT: 2**

2B In implementing the update for physician services, the Congress should require the Health Care Financing Administration to use a forecast of the change in input prices.

YES: 14 • NO: 0 • NOT VOTING: 0 • ABSENT: 2

2C The Secretary should not use an expenditure target to update the conversion factor in the outpatient prospective payment system or to update payments for other ambulatory care settings.

YES: 13 • NO: 0 • NOT VOTING: 0 • ABSENT: 3

2D The Congress should require an annual update of the conversion factor in the outpatient prospective payment system that is based on the relevant factors influencing the costs of efficiently providing hospital outpatient care, and not just the change in input prices.

YES: 14 • NO: 0 • NOT VOTING: 0 • ABSENT: 2

***COMMISSIONERS' VOTING RESULTS**

CHAPTER 2

Updating payments for physician services and for care provided in hospital outpatient departments

In this chapter

- Problems with the sustainable growth rate system for physician services
- Instituting a new approach for updating payments
- Controlling spending for physician services
- Updating payments for care in hospital outpatient departments

To help ensure beneficiaries' access to high-quality care, Medicare payments should correspond to the costs efficient providers incur in furnishing this care. To keep payments and costs synchronized over time, Medicare's payments for most services are updated annually. Two methods for updating payments include: (1) accounting for cost changes over time using an update framework, and (2) determining a target for spending and basing updates on whether spending is consistent with this target. For most services, updates to Medicare payments are based, at least in part, on the former approach. For physician services, however, a target for overall spending is determined according to the so-called sustainable growth rate system. The Medicare Payment Advisory Commission is concerned that this system fails to account adequately for changes in the cost of physician services and that it is a poor mechanism for controlling spending. Accordingly, we recommend replacing the sustainable growth rate system with an update method that better accounts for the cost of providing care. The Commission also is concerned that inconsistent methods for updating payments to different ambulatory care providers may lead to treatment decisions based on financial, as opposed to clinical, considerations. As a result, we recommend that updates under the prospective payment system for hospital outpatient services also be based on an update framework, rather than on an expenditure target.

Medicare's payments for physician services are made according to a fee schedule, under which services are given relative weights that reflect resource requirements. These weights are adjusted for geographic differences in practice costs and multiplied by a dollar amount—the conversion factor—to determine payments. The conversion factor is updated annually, based on a formula designed to control overall spending while accounting for factors that affect the costs of providing care.

Calculating the update to the conversion factor is a two-step process. First, the Health Care Financing Administration (HCFA) must estimate the sustainable growth rate (SGR), which is the target rate of growth in spending for physician services and is based on a formula defined in law. It is a function of the percentage changes in:

- input prices for physician services,
- traditional Medicare enrollment,
- real gross domestic product (GDP) per capita, and
- spending attributable to changes in law and regulation.

Second, HCFA calculates the update to the conversion factor. This update is a function of:

- the change in input prices for physician services,
- an adjustment factor that increases or decreases the update as needed to align actual spending with the SGR target, and
- other adjustments, such as budget neutrality adjustments required by the Balanced Budget Refinement Act of 1999.

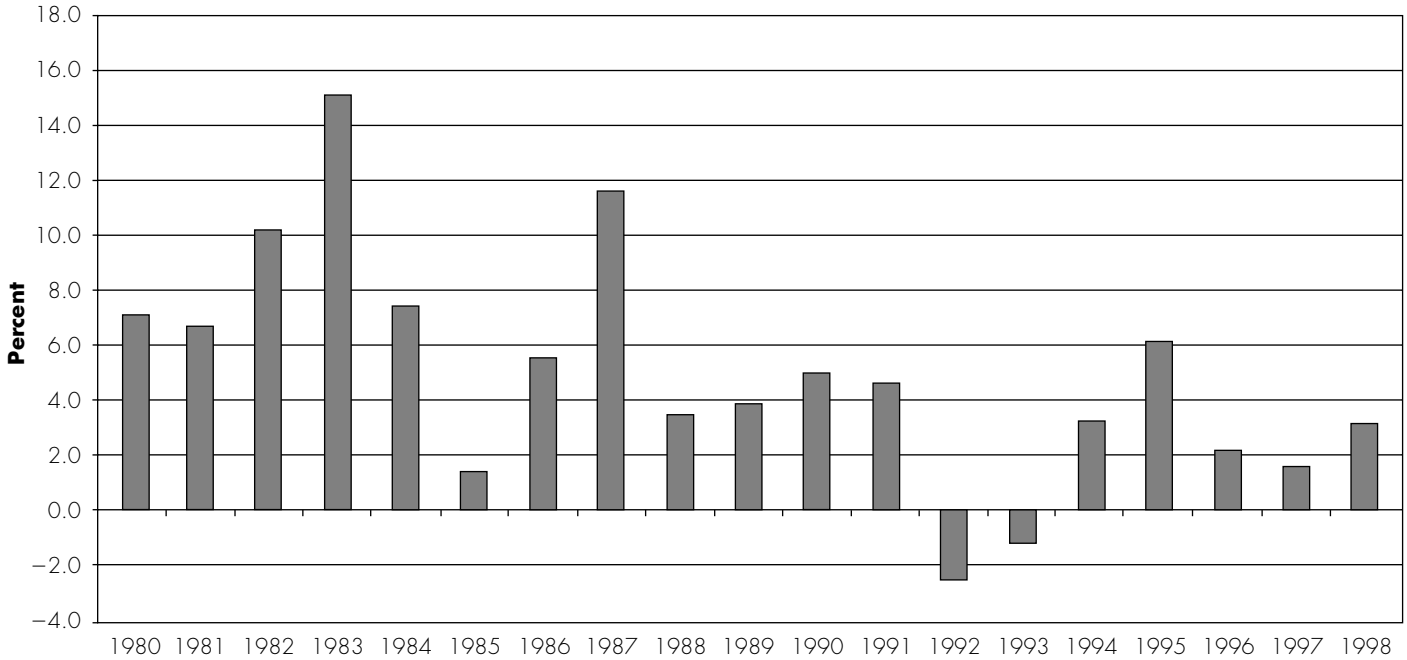
The update equals the change in input prices only if actual spending equals the SGR target. When actual spending is above the target, the update is less than the change in input prices; if actual spending is below the target, the update exceeds the change.

Use of an expenditure target to update payments began following passage of the Omnibus Budget Reconciliation Act of 1989—the Congress's response to rapid growth in Medicare spending for physician services. During the 1980s, annual growth in real spending per beneficiary for physician services ranged from 1.3 percent to 15.2 percent (Figure 2-1), with an average annual growth rate of 8.0 percent during 1980–1989. Since the fee schedule was introduced in 1992, growth in spending for physician services has slowed, with growth in real spending per beneficiary averaging 2.4 percent from 1991–1998.

This slowdown in spending, combined recently with relatively high growth in real GDP per capita, has led to updates exceeding the estimated change in input prices for physician services. For 2000,

FIGURE 2-1

Growth in real Medicare spending per beneficiary for physician services, 1980–1998



Note: Spending growth deflated by gross domestic product deflator.

Source: Board of Trustees, 1995, 1998, and 2000.

the update was 5.4 percent, based on an input price change of 2.4 percent, an update adjustment factor of 3.0 percent, and other adjustments of −0.1 percent. For 2001, the update was 4.5 percent, based on an input price change of 2.1 percent, an update adjustment factor of 3.0 percent, and other adjustments of −0.6 percent.

Problems with the sustainable growth rate system for physician services

In updating Medicare's payments for physician services, policymakers must answer two questions (MedPAC 1999). First, are current payment rates at the right level? And second, what factors should be taken into account in deciding how much to change that level over time? Answers to these questions are important because payment rates for individual services that are too low may limit beneficiaries' access to high quality care, while rates that are too high may encourage overproduction of services and unnecessarily burden beneficiaries and taxpayers. After reviewing the design of the SGR system, MedPAC concludes that it cannot maintain payment rates at the right level.

The system does not adequately account for all relevant factors that affect the cost of providing physician services. When making payment update recommendations to the Congress, MedPAC typically considers both factors affecting the current level of payment and factors expected to affect unit costs in the coming year, including changes in input prices, technology, and productivity growth, as well as one-time factors, such as implementation of new federal regulations. As discussed below, some of these factors are not relevant to updating payments for physician services, but the SGR system only addresses input price inflation and productivity growth; therefore, it does not fully account for changes in the cost of providing physician services.

More fully accounting for factors affecting costs would only solve one of the problems with the SGR system. Because this system adjusts updates for spending that is above or below an expenditure target, it can lead to payments that diverge from the costs of efficiently provided care.

Additionally, it is difficult to set an appropriate target for overall spending on care provided by physicians. Like all health care services used by Medicare beneficiaries, overall spending for physician services is influenced by many factors that are difficult to measure, including the preferences of patients and providers, the diffusion of technology, and the aging of the population. The situation is further complicated because physician services can be provided in a variety of ambulatory care settings—including physicians' offices, hospital outpatient departments, and ambulatory surgical centers—and because services are shifting from inpatient to ambulatory care and among ambulatory care settings (MedPAC 2000). Establishing the proper spending level while accounting for all these dynamics does not seem possible.

The SGR system attempts to sidestep these measurement problems with an expenditure target based on growth in real GDP. Such a target provides some assurance that growth in spending will be consistent with growth in the national economy and therefore affordable. Such a target, however, does not necessarily correspond to changes in the unit costs of providing necessary care of high quality.

Policymakers' difficulty in setting an expenditure target can have serious consequences for two reasons. First, because actual spending is unlikely to be the same as the target, updates under the SGR system can lead to payments that diverge from costs. If this occurs, payments will either be too low, potentially jeopardizing beneficiary access to care, or too high, making spending higher than necessary.

Second, the SGR system only applies to services paid for under the physician fee schedule. Because such services can be provided in several settings, updates based on an expenditure target that applies only to one setting could create financial incentives that inappropriately influence clinical decisions about where services are provided.

Even if the problems with setting an appropriate expenditure target could be overcome, it is unlikely that a mechanism like the SGR system could work as the Congress intended. When an expenditure target for physician services was first enacted in 1989, it was assumed that the system would provide physicians with a collective incentive to control the volume of services. This goal is unrealistic, however, because an individual physician reducing volume in response to incentives provided by the SGR system would not realize a proportional increase in payments. Instead, the increase in payments would be distributed among all physicians providing services to Medicare beneficiaries.

Instituting a new approach for updating payments

Given the problems with the SGR system, MedPAC recommends that the Congress consider a new approach to updating payments for physician services that more fully accounts for changes in the unit costs of providing those services. In considering payment updates of other Medicare services, MedPAC uses an update framework consisting of eight factors that address the appropriateness of the current level of payment and changes in costs expected to occur during the coming year (see text box, p. 24). The Commission believes elements of this framework could provide a promising basis for developing a new approach for updating payments to physicians.

The Commission also believes that payment updates for physician services should only account for changes in the

MedPAC's update framework

MedPAC uses a framework to develop update recommendations for Medicare's fee-for-service payment rates consisting of eight factors that may influence providers' payments or costs. The framework is intended to provide a basis for ensuring that payments continue to match the efficient cost of delivering high-quality patient care. To estimate the degree to which payments per unit (discharge, day, visit, or service) should rise or fall in the coming year, we estimate the percent changes (expressed as point estimates or ranges) attributable to each factor and sum them.

In assessing the adequacy of payment rates, policymakers ideally would first settle on an appropriate base rate and then consider the need for an update for the coming year. For this reason, MedPAC's framework first addresses factors affecting the appropriateness of the current level of payments and then turns to factors expected to change providers' costs in the coming year. Factors relating to the current level of payments are still ideally dealt with annually, however, as evidence of their effects on payments emerges. When this proves feasible, the "level" adjustments and "update" adjustments can be combined into a single recommended payment change for the next year.

Five components of the update framework address the appropriateness of current rates:

- **Correction for previous forecast error.** Inflation in input prices is measured using an index developed by the Health Care Financing Administration (HCFA) that comprises a fixed set, or market basket, of cost elements. Because the updates the Congress legislated previously were based on forecasts of price inflation, however, they are subject to inaccuracy. The Commission corrects for forecast error when actual data become available, generally two years after the update decision.

- **Unbundling of the payment unit.** A downward adjustment is made when there is evidence that cost reductions have been attributable to unbundling; that is, providers billing separately for services formerly within a single unit of payment. Unbundling can lower providers' costs without a corresponding reduction in Medicare's overall payment obligations. However, this component only applies in payment systems with a unit of payment that bundles services.

- **Coding changes across service categories.** Changes in case mix (that is, a shift in caseload to higher- or lower-paying classification groups) automatically change prospective payments. Changes in coding practices, however, can affect payments without any change in providers' resource needs. When there is evidence of such changes in coding, MedPAC makes an offsetting adjustment to bring payments back into alignment with efficient providers' costs.

- **Complexity changes within service categories.** A change in case complexity within a classification group—reflecting a change in the average severity of illness or other factors—can affect resource needs without a corresponding change in payments. A compensating adjustment is required.

- **Medicare policy changes affecting financial status.** Payment changes affecting the service that are legislated but not yet implemented should be considered in the updating process. A policy change that cuts payments does not automatically provide justification for an offsetting increase through the update, or vice versa, but the Commission may adjust the update that otherwise would apply if we believe the two changes together would have too large an effect on provider financial status.

Three components of the framework address cost changes expected in the next year:

- **Forecast of price inflation.** HCFA's forecast of the market basket estimates the rise in costs over the next year if there were no changes in the inputs providers use to furnish care or in the types of patients they treat.

- **Scientific and technological advancement net of productivity growth.** The allowance for scientific and technological advancement provides for the adoption of technological advances that enhance quality of care but also raise costs. Offsetting this amount is a downward adjustment for productivity growth, reflecting the savings MedPAC expects from fewer or less expensive inputs being used to deliver the services. Productivity improvements often result from the introduction of cost-reducing new technologies.

- **One-time factors.** This component provides the Commission with the flexibility to consider irregular factors outside the control of providers that are expected to have a systematic and significant impact on costs. For example, a one-time adjustment has been made for year 2000 computer problems, and the costs of complying with major new regulations might be considered in the future. If these impacts are expected to affect costs in a single year but not permanently, a negative adjustment is applied in a following year. ■

cost of efficiently providing care. If control of overall spending becomes an issue, other options, outlined later in this chapter, can be considered.

RECOMMENDATION 2A

The Congress should replace the sustainable growth rate system with an annual update based on factors influencing the unit costs of efficiently providing physician services.

Replacing the SGR system would be a major departure from current policy. As required by law, HCFA has updated the fee schedule's conversion factor with an expenditure target mechanism, in one form or another, since the fee schedule was introduced in 1992.[1] Basing the updates instead on factors influencing the unit costs of providing services requires answers to two questions: what factors are relevant to updating payments for physician services, and how can they be measured? Further work is necessary to answer these questions, but the Commission can offer some initial thoughts.

Four of the factors appear to be particularly relevant to updating payments for physician services: input price inflation, complexity changes within service categories, scientific and technological advancement (S&TA), and one-time factors. The discussion below addresses the relevance of these factors and begins to lay out how they could be considered in updating payments.

Input price inflation

In accounting for changes in the cost of providing services, changes in input prices are important for all services. In the update framework, this factor is defined as an estimate of how much costs are expected to rise in the coming year, holding constant the quality or mix of inputs providers use to furnish care and the types of patients they treat.

For physician services, a measure of input price inflation is already available: the Medicare Economic Index (MEI). Calculated by HCFA, the MEI is a weighted average of price changes for inputs used to provide care. These include physician time and effort (work), nonphysician employees, and office expenses. The MEI is similar conceptually to the market basket index in the update framework for inpatient hospital care, although it includes an adjustment for productivity growth. Productivity growth is accounted for differently in the update framework as it is applied to hospitals.

Including a productivity adjustment in the MEI prevents the double-counting of gains in labor productivity (HCFA 1991). Failure to remove improvements in productivity from the earnings estimates in the MEI would mean that physicians could be paid twice for productivity growth—once in the MEI and once for any increases in the volume and intensity of services that result from becoming more productive in their practices.

Measuring input price inflation

In the MEI, inputs used to provide physician services fall into two general categories: physician work and practice expense (Table 2-1). Practice expense includes nonphysician employee compensation, office expenses, medical materials and supplies, professional liability insurance, medical equipment, and other professional expenses, such as private transportation.

The weights used to construct the MEI represent the shares of physicians' practice revenues attributable to each input, based on a survey conducted by the American Medical Association. Physician work has a weight of 54.5 percent; the remaining 45.5 percent is allocated among categories of practice expense. The downward adjustment for productivity is measured as a 10-year moving average of growth in output per unit of labor in the general economy.

Basing updates on a forecast of input price inflation

Although payment updates should be prospective in that they attempt to anticipate changes in providers' costs during the coming year, the MEI (as used in the SGR system) is retrospective. Payments for a calendar year are based on data from the year ending the previous June 30.

RECOMMENDATION 2B

In implementing the update for physician services, the Congress should require the Health Care Financing Administration to use a forecast of the change in input prices.

The rationale for a retrospective MEI is not necessarily relevant today. As part of the 1972 amendments to the Social Security Act, the Congress mandated the MEI to update "prevailing" charges under the "customary, prevailing, and reasonable" (CPR) payment method. When it passed the legislation, the Congress's concern was that the CPR method was contributing to inflation in charges for physician services. Use of the MEI to update prevailing charges was intended to reduce this inflationary tendency, presumably by "follow[ing] rather than lead[ing] inflationary trends" (HCFA 1991). With implementation of the physician fee schedule in 1992, Medicare's payment rates for physician services were disconnected from charges, and assumed inflationary tendencies of the CPR method are no longer an issue.

If the Congress decides to use a forecast of input price inflation in updating payments, it will be necessary to make corrections for forecast errors. This can be accomplished easily by comparing the actual change in input prices, when known, with the forecast used to update payments.

1 The SGR system was in effect for the 1999, 2000, and 2001 updates. Previously, updates were determined by the volume performance standard (VPS) system. This system linked annual updates of the conversion factor to historical growth in the number and mix of physician services minus an adjustment factor. If volume growth in a year exceeded that allowed by the VPS, the update was adjusted downward two years later.

TABLE 2-1

Medicare Economic Index weights and measures of price change

Input	Weight (%) Category	Weight (%) Total	Measure of price change
Physician work		54.5	
Wages and salaries	44.2		Average hourly earnings, private nonfarm
Nonwage compensation	10.3		Employment cost index: benefits, private nonfarm
Practice expense		45.5	
Nonphysician employee compensation			
Wages and salaries	12.4		Employment cost index: wages and salaries, weighted by occupation
Nonwage compensation	4.4		Employment cost index: fringe benefits, white collar, weighted by occupation
Office expense	11.6		Consumer price index: urban consumers (CPI-U), housing
Medical materials and supplies	4.5		Producer price index (PPI): ethical drugs; PPI-surgical appliances and supplies; CPI-U, medical equipment and supplies (equally weighted)
Professional liability insurance	3.2		HCFA survey
Medical equipment	1.9		PPI, medical instruments and equipment
Other professional expense			
Professional car	1.3		CPI-U, private transportation
Other	6.3		CPI-U, all items less food and energy
All		100.0	

Source: HCFA 2000.

Questions about measuring input price inflation

Replacing the SGR system would make the MEI a more important factor in payment updates for physician services because the index would no longer be subject to the SGR system's adjustment for spending above or below an expenditure target. Questions about the MEI relate to its productivity adjustment and the measures of price change used in the index.

The productivity adjustment in the MEI is similar to the adjustment for productivity growth in MedPAC's update framework. Both adjustments account for changes in productivity that affect the cost of providing services; however, the MEI adjustment only accounts for growth in labor productivity. Under MedPAC's update framework, an adjustment for productivity ideally should be based on growth in multifactor productivity, measured as output per unit of combined labor and capital inputs.

This difference helps explain why the adjustment to the MEI has typically been larger than the productivity adjustment resulting from MedPAC's applying the update framework to hospital inpatient payments. The productivity adjustment in the MEI is 1.4 percent in 2001, compared with an adjustment of 0.5 percent for the update to hospital inpatient payments. The 1.4 percent adjustment in the MEI is the weighted average of a 1.9 percent adjustment for labor inputs and no adjustment for non-labor inputs, while the 0.5 percent adjustment is a policy standard, adopted by the Commission, based on growth in multifactor productivity in the private nonfarm business sector of the economy during the 1990s (BLS 2000).

The difference between these productivity measures raises the question of whether a multifactor measure would be appropriate for physician services. MedPAC's position is that a combined measure accounts for changes in productivity for all relevant inputs used to provide services, and thus captures the gradual substitution of capital for labor that has been occurring in the economy.

In addition to questions about the MEI's productivity adjustment, comments on proposed rules by HCFA have raised questions about some elements of the MEI (Wells 1998). One issue concerns the index's measure of physician work. The measure of price change for physician work is based on average hourly earnings for all nonfarm workers, but some believe the measure should instead be based on the earnings of professional and technical workers. This may reflect the nature of the services physicians provide more appropriately, and its use would make the MEI more consistent with the hospital market basket index.

Another issue pertains to the nonphysician compensation component of the MEI. Some argue that this component does not adequately account for changes in skill mix resulting from changes in technology and shifts in the site of care from hospitals to physicians' offices.

Complexity changes within service categories

In using its framework to consider updates for hospital payments, MedPAC attempts to take into account changes in patient complexity within existing patient classification groups. For example, the

shift of less complex cases from inpatient to ambulatory care has led to an increase in the average complexity of patients receiving care in the inpatient setting.

Using this factor in updating payments is only one step toward making payments consistent with changes in patient complexity; recalibrating a payment system's relative weights is also necessary. These actions together help ensure that the overall level of payment and payments for individual services remain consistent with changes in costs. If relative weights are recalibrated without accounting for patient complexity in the update, payments for one service can rise due to a change in patient complexity only if payments for another service fall.

Similar issues arise in considering an update for physician services. For example, the complexity of patients receiving coronary artery bypass grafts (CABGs) appears to have increased with the use of stents for the treatment of occluded coronary arteries (Health Economics Research 1999). Greater use of these stents may reduce the number of low-complexity CABG patients, thus increasing the cost of physician services for the typical CABG patient.[2]

Measuring change in within-service complexity for physician services is difficult. Detailed information is necessary on changes in patient characteristics and other factors. Information from reviews of the fee schedule's relative weights is currently used by HCFA only for recalibration, but it also might be useful for estimating changes in the cost of physician services due to changes in the complexity of specific services (see text box). Use of information from HCFA's reviews should be contingent on a change in the review process, however. Based on experience with the first five-year review, the agency is concerned that the process is limited in its ability to identify changes in service delivery that decrease cost, including cost-decreasing changes in patient severity (HCFA 1999).[3] A tendency under the current process to focus more on cost-increasing changes in patient severity would make an adjustment based solely on the review too high.

To address this issue, HCFA has hired a contractor to provide technical assistance on identifying services with inappropriate relative weights for physician work. The contractor has issued one report that discusses possible methods for identifying overvalued and undervalued services (Health Economics Research 1999). A second report will review alternative data sources (HCFA 2000).

Review of relative weights in the physician fee schedule

Under Medicare's fee schedule for physician services, services are assigned relative weights, reflecting resource requirements. These weights are adjusted for geographic differences in practice costs and multiplied by a dollar amount—the conversion factor—to determine payments. By law, the Health Care Financing Administration (HCFA) is required to review the fee schedule's relative weights at least every five years. The review must account for changes in medical practice, coding changes, new data, and the addition of procedures.

To fulfill this requirement, HCFA has implemented two similar processes. In the case of new and revised procedure codes, HCFA receives recommendations annually from the American Medical Association/ Specialty Society Relative Value Scale Update Committee (RUC). HCFA staff, working with medical directors from the carriers that process claims, review the recommended relative weights and compare them with the weights for other services. Then, HCFA establishes interim weights for new and revised codes, publishes them in the Federal Register, and revises them as necessary after considering public comments.

In the case of established or existing procedures, HCFA has developed a process known as the "five-year review," during which the agency solicits public comments on the relative weights for all services in the fee schedule and refers codes to the RUC. After review by the RUC, the process proceeds as for new and revised codes. HCFA completed the first five-year review in 1996. The second review is now under way. ■

Scientific and technological advancement

Medicare's payment policies account for technological advances in different ways, depending on the nature of the advance and the payment system. New services are defined as such in service classification systems, and relative weights are assigned by comparing the cost of each new service to the average cost of all services. An example of a new service is ocular photodynamic therapy for macular degeneration; HCFA extended Medicare coverage to include this service in November 2000.

Other advances affect the cost of providing existing services. Accounting for the costs of these advances requires an increase in the overall level of payment, followed by a budget-neutral recalibration of a payment system's relative weights. Recalibration of relative weights is necessary because the effects of new technologies are often service-specific.

A decision about whether to use an adjustment for S&TA as part of the update for physician services requires answers to

2 Relative weights in the physician fee schedule are based on the cost of a service for the typical patient.

3 In the update framework, cost-decreasing changes in services, other than changes in patient severity, are accounted for in the productivity adjustment.

two questions. First, is it possible to estimate expected changes in the cost of physician services due to technological advances for existing services? Second, how would HCFA recalibrate relative weights in the physician fee schedule to align them with service-specific changes in S&TA? The following discussion addresses these two questions.

Estimating changes in cost due to scientific and technological advances

Estimating changes in the cost of services due to new technology is difficult, as illustrated by MedPAC's experience considering an S&TA adjustment for hospital inpatient care. To establish a basis for a recommendation, MedPAC staff identify and describe major new technologies but do not attempt to quantify their impacts on hospital costs. Commissioners must then estimate an appropriate adjustment with little quantitative basis. To improve its method for measuring the effects of S&TA, the Commission plans to use a contractor, drawing on ideas from clinical consultants and meetings of expert panels, to assist with quantifying an S&TA adjustment.

One option for estimating an S&TA adjustment for physician services is to use information from reviews of the relative weights in the physician fee schedule. These reviews can include consideration of the various sources of change in costs for physician services, such as technology diffusion and learning by doing. For example, the five-year review completed in 1996 showed that HCFA needed to increase the relative weight for a pathology service: evaluation of fine-needle aspirate. When the weight for the service was initially determined in the late 1980s, this service was used primarily for screening and followed by a confirmatory biopsy. By 1996, the service had become a definitive diagnostic procedure from which treatment decisions were made, increasing the physician work necessary to provide it.

Recalibrating relative weights

If an S&TA adjustment to the payment update for physician services were implemented, recalibration of relative weights could occur as it does now, with HCFA calculating new relative weights and adjusting them for budget neutrality. Together, the payment adjustment and recalibration would ensure that payment increases are allocated to the services with changes in cost due to technological advancement.

One-time factors

The Commission recently revised its update framework to consider one-time factors that affect the cost of providing services, that are systematic and substantial, and that will improve care for Medicare beneficiaries.

An example of a one-time factor, which may be applicable to physician services, is the effect of new documentation requirements for evaluation and management services, a topic addressed in MedPAC's March 2000 report to the Congress. HCFA is revising documentation guidelines, which could result in an increase of the resources required to provide these services.

Requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) are another example of a one-time factor. HIPAA mandated federal standards for the protection of the privacy of personal health information, and implementation of these standards is expected to have an effect of the cost of providing physician services.

Aside from an adjustment for year 2000 computer improvements, MedPAC has not yet used one-time factors in its update recommendations.

Other factors in the update framework

Some of the remaining factors in MedPAC's update framework are probably not relevant in updating payments for physician services; others may be relevant to some degree but are not measurable. For example, it may not be necessary to consider the effects of changes in other Medicare payment policies because the physician fee schedule does not include other components (such as a medical education adjustment to payments for inpatient care) that affect the overall level of payments. Unbundling of the payment unit also is not an important issue in updating payments for physician services because the unit of payment is small (generally individually coded services). In addition, carriers that process Medicare claims use thousands of coding edits in their claims-processing software to detect unbundling, such as claims with two or more codes for services that should be billed under a single code.

Changes in coding practices may be relevant for some physician services if such changes occur without a change in the complexity of the services provided. In the case of hospital inpatient care, MedPAC evaluates coding changes based on an analysis of reabstracted medical records assembled by HCFA. A similar analysis may be possible for physician services, but data collection issues must be explored first.

Controlling spending for physician services

Payment updates such as those described in the previous section provide a means for controlling one component of spending growth: the price Medicare pays for individual services. The other component, growth in the volume and intensity of services, has not been a major concern since the physician fee schedule was introduced in 1992. The volume and intensity of physician services per beneficiary grew at an average annual rate of 3.2 percent from 1991 through 1998 (Board of Trustees 1998, Board of Trustees 2000), compared with 7.4 percent from 1980 through 1989 (Board of Trustees 1995). If volume growth reemerged as a concern, a better strategy might depend on:

- trying to achieve appropriate use of services through outcomes and effectiveness research;
- disseminating tools for applying this research, such as practice guidelines; and
- developing evidence-based measures to assess the extent to which knowledge is being applied (PPRC 1994).

Updating payments for care in hospital outpatient departments

In addition to recommending replacing the SGR system for physician services, the Commission also recommends steps toward establishing similar methods of determining payment updates for all ambulatory care services. As noted already, Medicare beneficiaries receive ambulatory care in a number of different settings, including hospital outpatient departments, ambulatory surgical centers, and rural health clinics. A variety of methods are used to update payments for services provided in each of these settings (see text box).

MedPAC has previously recommended against establishing a single overall expenditure target for physician services and ambulatory care facilities, as well as against establishing setting-specific

Payment update methods

Various methods are used to update Medicare's payments for ambulatory care facilities, including hospital outpatient departments, ambulatory surgical centers (ASCs), and rural health clinics (RHCs).

Hospital outpatient departments
Medicare's payments for hospital outpatient care are based on a fee schedule, the outpatient prospective payment system (PPS), under which services are classified into ambulatory payment classification (APC) groups. Relative weights are assigned to each group, and these weights are multiplied by a dollar conversion factor to determine payment amounts. By law, the conversion factor is updated annually by the hospital market basket index. In 2002, this update will be reduced by 1 percentage point.

The Secretary has two options for modifying the update. First, he can substitute an index specific to hospital outpatient departments for the hospital market basket index. The Health Care Financing Administration (HCFA) solicited comments on the design of a substitute index but received none, and is now working with a contractor to study the possibility of developing an index for outpatient departments.

Second, the Secretary may adjust the update for unnecessary increases in the volume of services. HCFA's interpretation of this provision is that an expenditure target is an option for updating the outpatient PPS conversion factor, but the agency so far has delayed implementation of any mechanism. The delay is intended to give hospitals time to adjust to the outpatient PPS and to give HCFA time to study methods for controlling the volume of outpatient services. A contractor has been hired to help with the study of options.

Ambulatory surgical centers
Since 1980, Medicare's Part B benefit has covered certain surgical procedures provided to beneficiaries in freestanding or hospital-based ASCs. ASC-approved procedures were originally assigned to one of four payment groups, with payment for each group calculated from cost and charge data from 40 ASCs. In early 1990, HCFA increased the number of payment groups to eight, based on 1986 survey data. In 1998, HCFA proposed replacing payments for these 8 groups with payments based on more than 100 APCs. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 delayed implementation of this proposed change in payments until 2002, when it will begin to be phased in over four years.

HCFA is required to update payment rates for procedures on the ASC list annually. To fulfill this requirement, the agency rebases payment rates every five years using data from a survey of a sample of ASCs. For years when payments are not rebased, payment rates are adjusted for inflation using the consumer price index for urban consumers. The Balanced Budget Act of 1997 reduced the update by 2.0 percentage points for fiscal years 1998-2002.

Rural health clinics
Payments to RHCs are based on an all-inclusive rate for each beneficiary visit for covered services. Covered services are primary and emergency care services furnished by physicians and certain nonphysician practitioners, and services and supplies incidental to these services. The all-inclusive per visit rate for an RHC is based on reasonable costs, as determined by a fiscal intermediary. With the exception of RHCs that are part of rural hospitals with less than 50 beds, these all-inclusive rates are subject to payment limits, which are updated each year by the Medicare Economic Index. ■

expenditure targets for other ambulatory care services (MedPAC 2000). Because HCFA did not remove an expenditure target from consideration in the April 7, 2000 final rule on the outpatient prospective payment system, the Commission reiterates its position.

RECOMMENDATION 2C

The Secretary should not use an expenditure target to update the conversion factor in the outpatient prospective payment system or to update payments for other ambulatory care settings.

Assuming HCFA will not use an expenditure target to update payments under the outpatient PPS, how should the agency proceed? The Balanced Budget Act of 1997 required annual updates equal to the hospital market basket index, minus 1 percentage point, through 2002. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 amended this requirement by permitting an update for 2001 equal to the hospital market basket index; it also allows the Secretary to adjust the outpatient PPS conversion factor for changes in coding or the classification of covered outpatient services that do not reflect real changes in service mix.

RECOMMENDATION 2D

The Congress should require an annual update of the conversion factor in the outpatient prospective payment system that is based on the relevant factors influencing the costs of efficiently providing hospital outpatient care, and not just the change in input prices.

As with physician services, the update for outpatient hospital care should be based on factors influencing the cost of providing services efficiently, including those factors in MedPAC's update framework. To update payments for outpatient hospital care in this way, questions that need to be addressed include:

- Should HCFA update the conversion factor for the outpatient PPS with the hospital market basket index or an index specific to outpatient departments?
- Is an update adjustment needed to account for new technologies not addressed by existing components of the outpatient PPS, including new-technology APCs and pass-through payments for drugs, biologicals, and implantable medical devices?
- What is an appropriate measure of expected productivity growth for outpatient hospital care?
- Given the small payment unit in the outpatient PPS, is unbundling an important issue?
- Can HCFA collect data on coding changes across service categories?
- Will any important one-time factors affect the cost of providing outpatient hospital care in the coming year?

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