

C H A P T E R

4

**Updating payment rates in
traditional Medicare**

R E C O M M E N D A T I O N

4A The Congress should not establish a single overall expenditure target that determines payment updates for physicians' services and ambulatory care facilities. Within existing statutory authority, the Secretary should not establish setting-specific expenditure targets.

Updating payment rates in traditional Medicare

MedPAC addresses fee-for-service payment issues in two categories: those that involve the distribution of payments (covered in Chapter 3) and those that deal with the level of payments. When a prospective payment system is developed, policymakers must establish a base rate designed to pay providers fairly and to ensure access to care. They also must update payments each year to account for changes in factors determining providers' costs; the update mechanism also can be used to control overall spending growth. This chapter discusses MedPAC's general approach, with appropriate customizing, to updating the prospective payment systems that have been or soon will be implemented. Ambulatory care presents unique challenges because the Congress has already established an "expenditure target" approach for updating payments to physicians. Although a consistent updating approach across all ambulatory care providers is desirable, the Commission believes that the complexity of the issues and competing policy objectives argue for caution in considering this approach.

In this chapter

- MedPAC's general framework for updating payments
- Applying the general framework to updating skilled nursing facility payments
- Updating payments to physicians and ambulatory care facilities

When developing a method for updating payments, policymakers must decide on policy objectives. The objective of maintaining consistency with efficient providers' costs is common to all update methods, but policymakers also may want to control total program spending.

Historically, differences in objectives have led policymakers to determine fee-for-service updates using two approaches. One builds the percentage update by examining historic trends and future projections for factors expected to affect providers' costs in the coming year. MedPAC and HCFA have used this approach to develop update recommendations for inpatient hospital services. The second approach takes into account some of the same factors but primarily considers whether cumulative changes in program spending are sustainable in light of projected changes in overall economic conditions. Some version of this "expenditure target" approach has been used since 1989 to set updates for the conversion factor in the physician fee schedule.

As Medicare implements more prospective payment systems (PPSs)—including those for skilled nursing facilities (SNFs), hospital outpatient departments, home health agencies, and rehabilitation hospitals—MedPAC expects to make several update recommendations each year. Where an expenditure target is not in place, the Commission has developed a general framework that accounts for the likely impact of a specific set of factors on patient care costs. Not all factors will be applicable or have significant effects in every setting, but the framework provides a starting point for developing an appropriate update for all prospectively determined payment rates and payment limits.

The first section of this chapter reviews this general update framework, and the second discusses its application to SNFs. Because the SNF PPS is new, the

Commission must decide how to construct a SNF update recommendation, including the analyses needed to support that effort. We do not anticipate recommending an update for SNFs until at least next year. However, MedPAC plans to recommend two payment updates—for inpatient hospital services in PPS and PPS-exempt facilities—in a June report on hospital payments.

The final section of the chapter addresses special issues involved in updating payments for ambulatory care provided by physicians, hospital outpatient departments, and ambulatory surgical centers. The Commission has considered the importance of achieving consistency in the updates for these three ambulatory care settings and addresses ways to achieve that consistency.

MedPAC's general framework for updating payments

The framework presented in this section for updating fee-for-service payments is based on a model developed by one of our predecessor commissions, the Prospective Payment Assessment Commission (ProPAC). Beginning in 1984, ProPAC's model was used to recommend annual updates for hospitals covered by the then-new PPS, as well as for inpatient facilities exempt from prospective payment.¹ In the more generic form presented here, the model can be adapted for application to any PPS where an expenditure target is not in place. As discussed later in the chapter, this may include hospital outpatient and ambulatory surgery center services if the Congress ultimately decides against using an expenditure target for care provided in those settings.

MedPAC's update framework is intended to provide a basis for measuring change in the efficient cost of delivering patient care. It takes into account seven cost-influencing factors, grouped into three

broad categories: changes in input prices, changes in inputs and product, and changes in case mix (Table 4-1). To estimate how much payments per unit (episode, discharge, day, or visit) should rise or fall in the coming year, we estimate the percent changes (expressed as point estimates or ranges) attributable to each cost-influencing factor and sum them.

The remainder of this section provides further detail on each of the three broad categories and seven specific components of the Commission's general update framework.

Changes in input prices

The first two components of the framework account for increases in the prices of inputs—staff, medical supplies, insurance, and so on—that providers use in delivering patient care. A two-step process is involved: forecasting the increase in input prices for the policy year and then adjusting for past forecast errors.

Forecast of price inflation

Inflation in input prices is measured using an index developed by HCFA that comprises a fixed set, or market basket, of cost elements, each with a weight and a price proxy that HCFA forecasts two years into the future. HCFA's forecast of the market basket indicates how much costs would be expected to rise if there were no changes in the inputs that providers used to furnish care or in the types of patients they treated.

HCFA has developed several service-specific market baskets, including those for PPS inpatient, PPS-exempt inpatient, home health, and SNF care. HCFA has not designated a market basket for dialysis services because payments for dialysis have not been updated in many years. In this case, MedPAC developed its own market basket on which to base update recommendations. These issues are discussed further in Chapter 6.

In past years, HCFA and ProPAC have disagreed on two issues in the

¹ PPS-exempt facilities include rehabilitation and psychiatric hospitals and units, as well as long-term, children's, and cancer hospitals. Under the terms of the Tax Equity and Fiscal Responsibility Act of 1983, these facilities are paid their average costs per case, subject to a facility-specific limit and a national 75th percentile cap. The annual update is applied to these limits and to the cap, rather than to payment rates as in the hospital inpatient PPS.

**TABLE
4-1****Components of
MedPAC's general
framework for
updating payments****Changes in input prices:**

Forecast of price inflation
Correction for previous forecast error

Changes in inputs and product:

Scientific and technological advances net of productivity growth
Unbundling of payment unit (as applicable)
One-time factors (as applicable)

Changes in case mix:

Coding changes across service categories
Complexity changes within service categories

construction of the hospital market basket, which led ProPAC to use an alternative market basket in developing its update recommendation. The issues involved the price proxy used for forecasting increases in employee compensation rates and the method for measuring capital prices. As discussed in the following paragraphs, MedPAC plans to change its approach in these areas to allow its update framework to be applied consistently across health care sectors.

The Commission's alternative market basket equally weights expected growth in employee compensation in hospitals and in the general economy, while HCFA gives less weight to the hospital projections. During the 1980s and early 1990s, HCFA's approach produced lower market basket increases because hospital wage growth exceeded that of the general economy. ProPAC believed that the larger wage growth was due at least partly to shortages of some types of specialized hospital personnel, and that this factor should be reflected in its update

recommendations. In today's era of low price inflation, the difference between the two treatments of employee compensation in the market basket is slight.

Consequently, we have decided to use HCFA's hospital market basket, and we will do the same for other health care settings.

Because hospital operating and capital payments have historically been updated separately, HCFA has maintained separate market baskets for operating and capital costs. After a 10-year transition to fully prospective payment for capital is completed in 2001, MedPAC believes that capital and operating payments should be combined.² If this is done, the Congress may elect to legislate a combined update.³ HCFA will then need to develop a single hospital market basket encompassing operating and capital inputs, as it has done for its home health agency and SNF market baskets. Until then, MedPAC will weight HCFA's separate forecasts of operating and capital input prices according to the proportions of national operating and capital costs (roughly 92 percent and 8 percent).

MedPAC has also used an alternative to HCFA's market basket for capital inputs, however. HCFA's market basket includes interest expenses, while MedPAC addressed the effects of changes in interest rates through a "policy financing adjustment" in the update framework. Over the past several years, low and stable interest rates have minimized the difference between MedPAC's and HCFA's approaches. Consequently, we have chosen to eliminate this separate adjustment and use HCFA's market basket.⁴

**Correction for previous
forecast error**

Because the updates the Congress legislates are based on forecasts, they are

subject to inaccurate estimating, which can make payments too high or low. MedPAC corrects for forecast error when actual data become available, generally two years after the update decision. This adjustment is important because the Congress has not allowed HCFA to adjust payments administratively when more current data become available. To date, MedPAC's correction factor has almost always been negative; for example, HCFA's forecast of inflation in hospital input prices proved to be higher than actual inflation for eight straight years.

**Changes in inputs
and product**

The next set of components in our update framework reflects added costs resulting from technological advances, possible savings from producing services more efficiently, and the cost effect of providers unbundling some services encompassed by the unit of payment (episode, discharge, day, or visit). In practice, we cannot precisely distinguish among these factors, but the framework provides a conceptual basis for considering each one. This set of factors addresses the change in inputs needed to deliver patient care while holding input prices and the mix of patients constant.

**Scientific and technological
advances net of
productivity growth**

Until now, MedPAC's update framework has included separate components for scientific and technological advances (S&TA) and productivity improvement. These two factors have generally been considered together because productivity gains are viewed as funding at least a portion of the costs of quality-enhancing technological advances. This tends to occur, of course, in nearly all sectors of the economy.

2 MedPAC's recommendation on this issue is presented in the hospital inpatient section of Chapter 3.

3 Currently, the Congress legislates an operating payment update, and HCFA implements a capital update through rulemaking.

4 The Commission intends to review some of the constructs of HCFA's market baskets in the coming year, focusing on the treatment of capital cost elements. In addition to using different methods for responding to changes in interest rates, MedPAC and HCFA have disagreed on the method for handling capital asset prices. HCFA's market basket is based on a moving average of depreciation expenses going back 22 years for buildings and fixed equipment and 10 years for movable equipment. MedPAC's market basket reflects a one-year change in asset prices for the coming year.

The provision for the cost effects of S&TA is forward looking; that is, it incorporates anticipated changes rather than historic ones, according to the Commission's analysis and judgment. It is intended to provide for the adoption of technological advances that enhance quality but also raise costs.

An offsetting downward adjustment is made to reflect the savings we expect from fewer or less expensive inputs being used to deliver the product. (In this context, "product" is measured in terms of the unit of payment.) This adjustment is also forward looking, reflecting the judgment that Medicare should require providers to reduce their inputs relative to outputs by at least a modest amount each year and that these reductions can be accomplished without adverse effects on quality of care. The effects of technological advances that reduce costs are accounted for in the productivity adjustment.

While there is little disagreement that both S&TA and productivity play an important role in determining the efficient costs of virtually all health care services, both are difficult to measure. Consequently, the Commission's decisions regarding the S&TA and productivity factors have been highly judgmental.

It has been virtually impossible to develop a single measure of productivity that we believe captures all aspects of input usage, measures a constant output over time, and is not contaminated by unrelated factors.⁵ In addition, it is nearly impossible to determine whether a measured reduction in inputs relative to outputs was accomplished without adverse effects on quality, which is a prerequisite to considering the reduction a real productivity improvement.

The best approach for dealing with this problem is to offset our S&TA adjustment with a fixed standard for expected productivity growth. Annually, we will determine whether to make an adjustment for S&TA beyond what can be covered by normal productivity growth. We will publish only the net S&TA factor, which would be zero when targeted productivity improvement exactly offsets the adjustment for S&TA.

Establishing a general productivity growth standard, of course, will be plagued by the same lack of data as our more narrowly focused measurement attempts in the past. Productivity trends in the national economy provide useful input, but in the end, the decision will undoubtedly remain judgmental. Consequently, establishing a fairly low guideline amount is appropriate—perhaps 0.5 percent annual improvement in the hospital sector, possibly lower (but not zero) in sectors such as home health and skilled nursing care, in which labor plays a more dominant role in delivering patient care.

Once the productivity standard has been set, we will not as a general rule attempt to measure sector-specific gains in productivity, instead focusing on technology-related analyses. Our goal will be to identify and analyze areas in which technological change is likely to have the largest impact, with input obtained from literature reviews, expert panels, and industry representatives.

Unbundling of the payment unit

The Commission has reduced its recommended payment update when there is evidence that cost reductions are attributable to unbundling; that is, providers are billing separately for services formerly within the unit of

payment. This phenomenon frequently lowers providers' costs without a corresponding reduction in Medicare's overall payment obligations.

In recent years, the Commission has recommended what we called a site-of-care substitution adjustment for our PPS inpatient update recommendation. This adjustment came in response to evidence that care formerly provided during inpatient stays had been unbundled and shifted to various post-acute providers who were paid separately.⁶ In 1987, ProPAC used this mechanism to account for hospitals unbundling diagnostic tests previously performed on the first day of a hospital stay and billing for them separately before admission.

The unbundling adjustment differs from the other two components composing the "changes in inputs and product" set in that it is intended to compensate for past events, not to adjust for factors expected to influence costs in the coming year. When necessary, the adjustment can account for the cumulative effects of unbundling over several years.

Despite the difficulty of measuring the cost impact of unbundling, adjusting for it in the update framework is essential because it can have a substantial effect on Medicare's payments.⁷ The financial incentive to cut the length of inpatient stays by transferring patients to other settings is intrinsic to per-discharge payment; in fact, the incentive to unbundle services for separate billing is intrinsic to prospective payment of any kind. Thus, while the Commission's use of the unbundling adjustment has been limited to PPS inpatient services to date, it may well come into play for updating other prospective rates in the future.

5 MedPAC is not the only organization to experience this frustration. The Bureau of Labor Statistics has published productivity measures for nearly all major sectors of the economy. However, due to some of the same problems that have plagued MedPAC's analyses, it has been unable to develop measures for hospitals and other health care providers.

6 Although MedPAC believes that a substantial portion of the decline in hospital lengths of stay during the 1990s was due to a shift in care from acute to post-acute settings, some of the reduction is due to other factors. An example is endoscopic surgery, which allows patients to reach the same level of functioning in less time, compared with invasive surgical techniques.

7 Accounting for unbundling through the updating process spreads the impact of the downward payment adjustment across all cases. Another method of accounting for unbundling in an inpatient setting is to use a graduated per diem payment in place of the normal per-case payment for the specific cases in which unbundling has occurred. This general approach—known as the expanded transfer policy—has been used for the hospital inpatient services covered by Medicare's PPS. As discussed in Chapter 3, MedPAC endorses the expanded transfer policy in combination with the unbundling adjustment in our update framework.

One-time factors

This component provides the Commission with the flexibility to consider irregular factors outside the control of providers that may have systematic and significant impacts on costs. Last year, for example, the Commission considered the impact of year 2000 computer problems in this category.⁸ Other factors could include new financial reporting requirements, safety standards, and taxes.

Changes in case mix

The final segment of the update framework adjusts for case-mix change, with prices and inputs held constant, to account for changes in patients' real resource requirements over time. The two components of MedPAC's adjustment for case-mix change address the impacts of coding changes (often referred to as upcoding) and real changes in patient needs—complexity—within service classification categories.

Coding changes across service categories

In a PPS, the resource intensity of the services patients require is measured by a case-mix index, which reflects the distribution across the classification groups used for payment. These groups are constructed using some combination of services provided and patient characteristics. For example:

- The ambulatory payment classifications HCFA will use for its hospital outpatient PPS are based exclusively on services.
- The resource utilization groups used in the SNF PPS are based mostly on services.
- The diagnosis related groups (DRGs) used in the hospital inpatient PPS and the home health utilization groups that HCFA has proposed for home health PPS are based predominantly on patient characteristics.

Increases in a case-mix index automatically raise prospective payments, which is appropriate when the growth results from real change in patient resource requirements. Changes in coding practices, however, can raise or lower the index without any change in resource needs. The Commission attempts to estimate how much of the index growth in the previous year is attributable to changes in coding and recommends an adjustment of that amount for the update. The coding change factor will apply in all of Medicare's PPSs except dialysis, where a single base payment rate is used for all patients.

MedPAC considers this adjustment essential because upcoding is likely whenever prospective payment rates are set using a patient classification system—especially in the first year or two after a PPS is implemented. Upcoding does not necessarily indicate abusive billing practices; it may also result from improvements in medical record documentation and coding technique, which are natural outgrowths of providers learning to classify their patients or adopting to changes in the structure of the classification system.

Complexity changes within service categories

A change in service complexity within classification groups—reflecting a change in the average severity of illness or other factors—can affect resource needs without a corresponding change in payments. The Commission will recommend an adjustment to the update when it believes this has occurred.

Unlike upcoding, however, changes in within-class complexity over time are often small; therefore, in many cases it may not be necessary to invest the resources needed to measure within-class complexity. Nonetheless, our general framework should include this factor because it may be significant in certain circumstances. For example, ProPAC recommended within-DRG case-complexity adjustments of a full

percentage point or more for hospital inpatient services in the 1980s. The larger change at that time was attributed primarily to the shift of non-complex cases within some DRGs to outpatient settings, raising the average severity level of the remaining cases.

Hospital outpatient and SNF services would appear to be the most likely candidates for significant levels of within-class complexity growth in the near future because broad classification categories are employed for payment and because some of the services can also be provided in other settings. Case-complexity change may also influence costs in dialysis and PPS-exempt inpatient facilities, but we are hampered in our ability to measure it in these settings by the lack of patient classification systems.

Applying the general framework to updating skilled nursing facility payments

Medicare has recently implemented a PPS for care in SNFs and the Commission's recommendations for updates to SNF payments will be based on the general update framework discussed above.

Although the update amount is set in law, policymakers will need to know whether the statutory updates are consistent with an analytically informed judgment about how much these rates should increase from one year to another. Over the next year, MedPAC will develop the details of the framework as it applies to SNFs. In 2002, the Commission will have complete cost report data under the PPS to inform its recommended update.

An adjustment for unbundling will not be used for determining update recommendations for SNF payments. SNFs may be on the receiving end of hospitals' unbundling, but because these facilities are paid on a per diem basis, the financial incentives associated with shortening lengths of stay do not appear to

⁸ Because we had not defined this "one-time factors" category separately as of our March 1999 report, the year 2000 adjustment was combined with our S&TA allowance.

exist. Consolidated billing for all services to SNF patients also makes it unlikely that facilities can unbundle services. The following sections address applicable elements of the update framework. MedPAC will solicit the advice of experts to inform its decisions on several components.

Changes in input prices

HCFA developed a new SNF market basket to generate PPS rates and account for annual changes in input prices, using fiscal year (FY) 1992 data (the most recent year for which relatively complete data were available).⁹ The SNF market basket contains 21 items in 6 major expense categories: wages and salaries, employee benefits, contract labor, pharmaceuticals, capital-related costs, and other costs.

The market basket reflects the labor-intensive nature of SNF care; 76 percent of the market basket for FY 1999 is labor related, about 10 percent more than the labor-related share for the PPS hospital combined operating and capital market basket. MedPAC will correct for forecast errors in the SNF market basket as the actual data become available, generally two years after the forecast is made.

Changes in inputs and product

The update adjustment for changes in inputs and product considers an allowance for S&TA net of targeted productivity growth. As it does for other providers, the allowance for the cost effects of S&TA is intended to provide additional funds for SNFs to adopt health care advances that enhance quality but also raise costs. The Commission is concerned about the impact of pharmaceuticals on SNF costs and will therefore focus on this area in studying the effect of S&TA on SNF costs. In addition, in deciding about the S&TA allowance, MedPAC will consider whether technologies are approved by the Food and Drug Administration (FDA), the proportion of SNF patients potentially affected, and treatment costs.

The Commission will develop a standard target for productivity improvement in SNFs, after discussing with experts the extent to which expecting productivity improvement is realistic in such a labor-dependent setting. As stated earlier, once the productivity standard has been set, we will not as a general rule attempt to measure productivity gain but will focus instead on measuring technological change. The productivity improvement target will be deducted from the S&TA allowance.

Changes in case mix

MedPAC will construct a baseline case-mix index (CMI) for SNFs by measuring changes in case mix and estimating the portion of the annual change that is real (reflecting changes in patient resource requirements, rather than improvement in coding). Based on this analysis, the Commission will adjust its update recommendation for coding changes in SNFs.

Determining the amount of CMI change due to real changes versus coding changes will be difficult, and the Commission plans to consult with experts to identify measures of these changes. Because of experience with the hospital PPS, we will focus on coding changes while these facilities are adjusting to being paid prospectively. Studies conducted after the implementation of the DRG classification system generally found that the proportional effect of improved coding was most pronounced following structural changes in the hospital classification system. Many structural changes are already planned for the SNF PPS, including phase-in from 1998 through 2002, temporary increases in payment rates for some case-mix groups in 2000, and refinements to the PPS in 2001. The Office of Inspector General plans a study of the accuracy of coding, which also may inform MedPAC's analysis.

As stated above, complexity changes within case-mix groups may be more evident in SNFs than in some other service units because of the large groups in the PPS. The Commission will examine

Minimum Data Set (MDS) elements for patients within the same case-mix group to determine whether complexity changes within Resource Utilization Groups, Version III (RUG-III) have occurred.

Updating payments to physicians and ambulatory care facilities

Medicare payments to physicians and ambulatory surgical centers (ASC) are based on fee schedules, and payments to hospital outpatient departments (OPD) will be based on fee schedules later this year. Medicare payment policies require annual updates of these payments, but methods vary. The following discussion considers the importance of achieving consistency in these updates and addresses ways to achieve that consistency.

As explained at the beginning of this chapter, Medicare has experience with two approaches to determining fee-for-service updates. One is an update framework that examines historic trends and future projections for factors expected to affect providers' costs in the coming year. The other is an expenditure target. Policymakers employ expenditure targets when they believe controlling overall expenditures is as important as updating payments to account for changes in providers' costs. To date, only physicians' services have been subject to an expenditure target. However, the Congress has directed HCFA to develop a method for controlling unnecessary increases in the volume of hospital outpatient services, and HCFA has proposed an expenditure target as a possible way to fulfill that requirement (HCFA 1998a).

In addition to accounting for increases in providers' costs while controlling spending, updating payments to physicians and ambulatory care facilities must take into consideration the fact that services may be provided in multiple settings. Making consistent updates

9 The previous SNF market basket, which excluded ancillary and capital-related costs, was inappropriate because the PPS now includes those costs, in addition to the costs of routine services.

among settings may be important if payment differentials lead to undesirable shifts of services among settings.¹⁰

Concern about update consistency across settings prompted the Commission to recommend a single update mechanism that would link payment updates across all ambulatory care services, including those provided in physicians' offices, OPDs, and ASCs (MedPAC 1999). However, the Commission has recently revisited its position. Based on further analysis and consideration, MedPAC has concluded that, while consistency in updates is conceptually desirable, complex issues must be resolved before that goal can be achieved.

RECOMMENDATION

The Congress should not establish a single overall expenditure target that determines payment updates for physicians' services and ambulatory care facilities. Within existing statutory authority, the Secretary should not establish setting-specific expenditure targets.

Further work is necessary on a method other than an expenditure target that brings about consistency in updates. The following discussion introduces issues that must be resolved before consistency can be achieved. It discusses why consistency in payment updates is desirable and then describes alternative approaches that would bring about this consistency.

Rationale for consistency in payment updates

Shifts of services among ambulatory care settings—physicians' offices and ambulatory care facilities—can occur for a variety of reasons. Such changes are desirable if they reflect changes in

medical capabilities and technology, patient mix, or practice patterns and if they lead to improved patient outcomes. Consistent payment levels and updates among ambulatory care settings would minimize incentives to shift services among those settings due to financial, instead of patient care, considerations.

To examine the issue of potential shifts among settings, we analyzed physician claims data because physicians provide services in multiple settings.¹¹ We calculated the shares of spending, by setting, for physicians' services for each of five years (1994–1998) for specific physicians' services offered in at least two of three settings: OPDs, physician offices, and ASCs. Changes in those shares among settings were interpreted as shifts in services.¹²

We examined shifts specific to single services only; that is, shifts from one setting to another with no change in the type of service. (Another type of shift involves replacing one service with another; for example, drug therapy that replaces surgery.)

The results show the potential for shifting services among ambulatory care settings (Table 4-2). In the case of cataract lens replacements, for example, the data suggest that procedures performed in ASCs have replaced procedures performed in OPDs.¹³ For other cases—such as echocardiograms and nuclear imaging—data suggest the potential for shifting services from OPDs to physicians' offices. Finally, data suggest that for colorectal endoscopy and upper gastrointestinal endoscopy, decreasing spending shares for services in physicians' offices are offset by increasing spending shares for ASCs.

Such shifts in services may lead to improved patient outcomes. Because of the Commission's concern that financial considerations could lead to undesirable shifts of services, we are beginning to consider alternative approaches to updating payments to physicians and ambulatory care facilities.

Alternative approaches to updating payments to physicians and ambulatory care facilities

Given the rationale for consistently updating payments to physicians and ambulatory care facilities, what are the options for doing so? The Commission has considered two options: an update framework, similar to those used by MedPAC and HCFA to determine updates for hospital inpatient PPS payments, and an expenditure target, modeled after the SGR system used to update payments under the physician fee schedule.

In considering these options, the Commission has viewed consistency of updates to be distinct from uniformity; using an update framework, changes in input prices could yield consistent updates that would be different for each setting. In contrast, uniform updates would be the same for all applicable settings.

Update framework

Payment updates for physicians and ambulatory care facilities could be based generally on MedPAC's update framework. Current updates take into account changes in input prices. Adjustments to payments for changes in inputs and product would require careful thought about how changes in technology and productivity affect ambulatory care, as well as whether unbundling concepts

10 Consistency of updates is part of the broader issue of consistency of payments among settings, which includes the appropriateness of base payment rates, in addition to consistency of updates. As discussed in the introduction of this chapter, the Commission has begun deliberating the appropriateness of some base payment rates, but it is not making any recommendations on those issues in this report.

11 Because physician claims data do not include services provided by residents, the analysis did not consider shifts of services attributable to delivery of these services.

12 In other contexts, the analysis would be a "market share" analysis. Total expenditures for a service would be the market, and each setting's share of expenditures would be its market share.

13 The small share of spending for cataract lens replacement in the office setting represents visits to physicians and other professionals for pre-operative and post-operative care.

Payment update methods

Medicare's payment update methods vary for physicians' services, hospital outpatient departments, and ambulatory surgical centers.

Physicians

The Omnibus Budget Reconciliation Act of 1989 required payment for physicians' services under a fee schedule and established the Volume Performance Standard (VPS) system to curb the rise in spending for physicians' services. The VPS system linked payment to growth in the number and mix of services physicians provide. Each year, the VPS system set target rates of spending growth called performance standards. Two years later, actual spending growth for that year was compared with the target; then, the conversion factors, used to determine payment amounts, were adjusted to hold growth in overall spending to the target rates. These adjustments were called conversion factor updates.

The Balanced Budget Act of 1997 (BBA) replaced the VPS system with a sustainable growth rate (SGR) system, in which updates to physician payments are determined by the Medicare Economic Index and an update adjustment factor. Calculating the update adjustment factor involves comparing actual spending for physicians' services against a target, which is determined by the sustainable growth rate.

Four factors make up the sustainable growth rate:

- the percentage change in input prices for Medicare physicians' services,
- the percentage change in Part B enrollees (excluding those enrolled in Medicare+Choice plans),

- the projected change in real gross domestic product (GDP) per capita, and
- the percentage change in spending for physicians' services resulting from changes in law and regulations (but not due to the SGR system).

The real GDP per capita factor in the SGR allows the target to accommodate increases in the volume and intensity of physicians' services, but only at a rate supported by growth in national income.¹⁴

The Balanced Budget Refinement Act of 1999 changed the SGR system in several ways. First, calculation of the update adjustment factor was modified to reduce potential oscillation in payment updates. Second, the Secretary was required to revise previously issued SGRs with the best available data, beginning with the SGR for 2000. Third, the Secretary was required to conduct a study of the use of physicians' services by Medicare beneficiaries, including the effects of improvements in medical capabilities, advancements in scientific technology, and other factors. MedPAC must analyze and evaluate the study and report to the Congress on it. Fourth, the Secretary was required to make available to MedPAC and the public each year an estimate of the SGR and the conversion factor applicable to physician payments for the succeeding year.

Hospital outpatient departments

Medicare reimburses hospitals for most outpatient services using three different payment methods depending on the type of service: the least of costs or charges; the least of costs, charges, or a blended rate; and a number of fee schedules (for clinical laboratory

services, prosthetics and orthotics, and durable medical equipment).¹⁵ Originally, Medicare paid for all hospital outpatient department (OPD) services the lesser of costs or charges. However, Medicare has been moving away from this method because it offers no incentives for cost control. In 2000, a prospective payment system (PPS) for OPDs will replace existing payment methods. Under the PPS, services will be classified into Ambulatory Payment Classification (APC) groups, with one payment rate for all services in an APC.

To reduce Medicare's hospital outpatient expenditures, the Congress made across-the-board cuts in both operating and capital payments. In fiscal years 1990 and 1991, Medicare payments for hospital outpatient capital costs were reduced by 15 percent. Since fiscal year 1991, operating payments for hospital outpatient services paid on a cost basis (as well as the cost portion of blended payments) have been reduced by 5.8 percent. This 5.8 percent reduction in payments for operating costs has also been applied to part of the blended payment for radiology, other diagnostic procedures, and ASC-approved surgery. These reductions were set to expire at the end of 1998, but the BBA extended them to December 31, 1999. Since fiscal year 1992, payments for capital have been held at 10 percent below costs each year.

As part of the OPD PPS, the Secretary will update payments using the hospital market basket index, which measures input prices for inpatient hospital care. The Secretary also has the option to use an OPD-specific index computed in the same manner as the hospital market basket index. Finally, the Secretary may adjust the update for unnecessary increases in the volume of services.

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14 Further details on the SGR system are discussed in MedPAC's March 1999 report to the Congress.

15 The blended rate combines a fee schedule amount with the lesser of costs or charges.

Payment update methods

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Ambulatory surgical centers

Since 1980, Medicare's Part B benefit has covered certain surgical procedures provided to beneficiaries in freestanding or hospital-based ambulatory surgical centers (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 eight groups with payments structured in terms of more than 100 APCs. HCFA is expected to implement payment rates, by APC, during 2000.

HCFA is required to annually update the payment rates for procedures on the ASC list. To fulfill this requirement, the

agency rebases the 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. The Social Security Act provides for increasing ASC payment rates by the percentage increase in the consumer price index for urban consumers. The BBA reduced the update by 2 percentage points for fiscal years 1998–2002. ■

apply to the relatively small service units. In addition, framework adjustments for changes in case mix would have to be adapted to account for the fact that ambulatory care payments are based on a service classification system, rather than a case-mix classification system.

Even if the update framework could be applied to physicians' services and ambulatory care facilities, two important issues remain. One concerns coding and service use incentives under the OPD PPS. The other concerns continued use of the SGR system for updating payments to physicians.

Implementation of the outpatient department prospective payment system

For some services, pre-PPS payments to OPDs have been determined on the basis of OPD costs. This payment method was applied retrospectively, on an aggregate basis, during the settlement of the hospitals' Medicare cost reports. This aggregate settlement of payments and costs was not dependent on the specific services provided in OPDs and did not provide hospitals with an incentive to accurately report which services were provided.

Under the OPD PPS, accurate reporting of services provided will become much more important. Payments will depend on the billing code assigned to each service. Each code will be assigned to an Ambulatory Payment Classification (APC) group, and each APC will have a payment rate.

Evaluation and management services, which include visits to OPDs and physicians' offices, illustrate the change in incentives that will occur when the OPD PPS is implemented. Before introduction of the PPS, hospitals were instructed to use one billing code for new patients and another for established patients, regardless of the duration or complexity of a visit (HCFA 1999). Use of other codes, more consistent with the level of service provided, was permitted but not required.

In accordance with instructions received from HCFA, hospitals have been most likely to use the lowest-level code available—99201—when reporting visits by new patients, while physicians are most likely to use a higher-level code—99203—when providing the same types of visits (Figure 4-1). The coding of visits by established patients also differs between OPDs and physicians, although the difference is not as great as that for new patients (Figure 4-2). Still, some shifts in OPD coding seem necessary for their pattern to become more like that for physicians.

The differences in coding of evaluation and management services between OPDs and physicians suggests that introduction of the OPD PPS could lead to increases in payments to OPDs, all other things being equal. Such increases would not reflect changes in OPD costs, but rather changes in coding practices, and would be difficult to distinguish from other factors

influencing payment increases, such as increased use of services.

One way to address changes in coding under the PPS would be to establish a feedback relationship between coding changes and the PPS conversion factors; spending that differed from projections would lead to changes in the conversion factor. HCFA has considered this approach and is planning further study of other options (HCFA 1998a).

An update framework and the sustainable growth rate system

A second issue that must be resolved before an update framework could be used for physicians' services and ambulatory care facilities concerns the SGR system for updating payments to physicians.

The Congress refined the SGR system in the Balanced Budget Refinement Act of 1999 (BBRA) and appears committed to its continued use. Replacing this system with an update framework that does not include an expenditure target for physicians' services does not appear to be consistent with congressional preferences.

A compromise between moving toward an update framework and staying with the current expenditure target approach might focus on applying the update framework to the part of physician payments most analogous to facility payments—the practice expense payments. Practice expense payments are intended to compensate physicians for expenses similar to those of ambulatory care

**TABLE
4-2****Expenditure shares for selected physicians' services provided in ambulatory care settings, by setting, 1994-1998**

Type of service	Percentage of 1998 ambulatory care physicians' services expenditures	Share of physicians' services expenditures within category					Direction of change in share of expenditures
		1994	1995	1996	1997	1998	
Visits, office/outpatient	31.2%						
Office		97.6%	97.3%	97.0%	96.9%	96.9%	decrease
OPD		2.4	2.7	3.0	3.1	3.1	increase
Cataract lens replacement	4.7						
Office		2.3	2.2	2.1	2.7	2.5	increase
OPD		64.5	63.9	62.8	60.6	59.7	decrease
ASC		33.3	33.9	35.2	36.7	37.8	increase
Consultations	4.4						
Office		92.0	92.0	92.0	92.1	92.3	increase
OPD		7.9	7.9	7.9	7.8	7.7	decrease
Routine diagnostic radiology	3.9						
Office		66.7	66.2	67.6	66.5	68.3	increase
OPD		33.2	33.7	32.3	33.4	31.6	decrease
Therapeutic radiology	3.2						
Office		60.3	61.2	62.2	64.2	65.9	increase
OPD		39.7	38.7	37.8	35.8	34.1	decrease
Echocardiograms	2.7						
Office		82.2	85.2	87.5	87.8	88.3	increase
OPD		17.8	14.8	12.5	12.2	11.6	decrease
Electrocardiograms	2.6						
Office		83.3	80.9	81.7	81.9	82.0	decrease
OPD		16.6	19.0	18.3	18.1	18.0	increase
Magnetic resonance imaging	2.3						
Office		84.7	84.3	85.0	85.2	84.9	increase
OPD		15.3	15.7	15.0	14.7	15.1	decrease
CAT scans	2.2						
Office		51.4	50.4	51.6	51.9	51.9	increase
OPD		48.6	49.6	48.4	48.1	48.1	decrease
Nuclear imaging	2.0						
Office		65.7	69.9	74.9	77.9	80.2	increase
OPD		34.3	30.1	25.1	22.1	19.8	decrease
Colorectal endoscopy	2.0						
Office		22.9	19.8	18.1	16.2	14.1	decrease
OPD		67.8	69.2	69.6	69.9	70.7	increase
ASC		9.3	11.1	12.3	13.8	15.2	increase
Ultrasound imaging (non-cardiac)	1.4						
Office		81.9	82.1	82.0	81.4	80.5	decrease
OPD		17.9	17.8	17.9	18.3	19.3	increase
Upper GI endoscopy	0.9						
Office		9.8	8.5	7.3	7.1	6.2	decrease
OPD		81.7	80.6	80.4	79.8	80.3	decrease
ASC		8.5	10.9	12.2	13.1	13.6	increase
Cardiac catheterization	0.6						
Office		11.7	14.6	14.8	17.3	17.4	increase
OPD		88.1	85.2	84.9	82.4	82.2	decrease
Arthroscopy	0.4						
Office		1.9	1.7	1.6	1.5	1.7	decrease
OPD		85.1	86.4	84.7	84.9	83.2	decrease
ASC		12.9	11.9	13.7	13.6	15.1	increase
Total	64.5						

Note: Data are from the first six months of each year. OPD (outpatient department), ASC (ambulatory surgical center), CAT (computerized axial tomography), GI (gastrointestinal).

Source: MedPAC analysis of 1994-1998 Medicare physicians' service claims, 5 percent sample of beneficiaries.

Understanding shifts of services to ambulatory surgical centers

One factor influencing shifts of services to ambulatory surgical centers (ASCs) is capacity: The number of facilities has grown rapidly. From 1993 to 1997, the number of Medicare-certified ASCs increased from 1,715 to 2,470, an average annual increase of 9.5 percent.

Another factor is ongoing changes in the delivery of medical care. Three types of procedures—arthroscopy, endoscopy, and cataract lens replacement—illustrate these changes.

Arthroscopy

Changes in practice patterns are a primary reason for the increase in the volume of arthroscopic procedures. Arthroscopy, used to diagnose and treat joint problems and most commonly performed on the knee, has virtually replaced open-joint surgery for most indications. Arthroscopy is generally a less invasive, more accurate, and more precise method of diagnosis. It frequently allows very early post-operative ambulation, is generally associated with fewer complications, and is less costly if hospitalization is unnecessary. Because this procedure is less invasive and has a lower complication rate, more doctors are

likely to recommend it, and a larger number of patients are likely to undergo it, even for less severe symptoms. Although most arthroscopic procedures are performed in outpatient departments, the share performed in ASCs is growing (Abt Associates 1993).

Endoscopy

Colonoscopy and upper gastrointestinal (GI) endoscopic procedures have increased in volume due to advances in technology, changes in practice patterns, increases in capacity to provide these services, and changes in patients' attitudes. Endoscopes allow physicians to diagnose and treat upper and lower GI tract problems. Several technological advances have allowed for more accurate and less invasive procedures. For example, the flexible fiberoptic scope replaced rigid scopes in the mid-1970s. Video devices and surgical accessories have also permitted better diagnosis and treatment. Changes in practice patterns—such as the general decrease in the use of contrast radiologic studies as diagnostic tools—have also influenced volume growth of endoscopic procedures. Additionally, a greater understanding of colon cancer

and events that increase the malignant potential of colonic polyps has led to a greater willingness to recommend sigmoidoscopy for cancer screening purposes.

The number of physicians performing these procedures has also increased dramatically, especially for the lower GI tract. At least half of all family and general practitioners, as well as internists, are trained in flexible sigmoidoscopy (ACS 1990).

Cataract lens replacement

Cataract lens replacement has been influenced by technological advancement and the aging of the population. Microsurgery and ultrasound techniques permit surgeons to make smaller incisions, reducing time required for post-operative recovery. Meanwhile, as technology lowers the threshold for recommendation and acceptance of surgery, the number of candidates for surgery has increased. This is occurring because of the aging of the U.S. population and because age is strongly correlated with cataract risk. ■

facilities—nonphysician clinical staff, administrative staff, rent, supplies, and equipment. Using an update framework for these payments could improve consistency across settings while leaving the SGR to control growth in payments for physicians' work and professional liability insurance (PLI) expenses.¹⁶

In considering this option for updating payments, policymakers should be aware that it could lead to differences in the two physician fee schedule conversion factors.

For example, if separate updates had been implemented for physician payments in 2000, the practice expense conversion factor would have increased by 2.4 percent, the Medicare Economic Index (MEI) for 2000.¹⁷ The work and professional liability insurance conversion factor would have increased by the MEI of 2.4 percent, plus an update adjustment factor of 5.2 percent, for a total increase of 7.6 percent.¹⁸ After the increases, the conversion factors would have been \$35.56 for practice expenses and \$37.37

for work and PLI. These conversion factors could become quite different over time.

The Commission has not yet reached a conclusion on the advisability of separate updates for different components of the physician fee schedule.

Expenditure targeting

An expenditure target is another option for updating payments to physicians and ambulatory care facilities. In contrast to

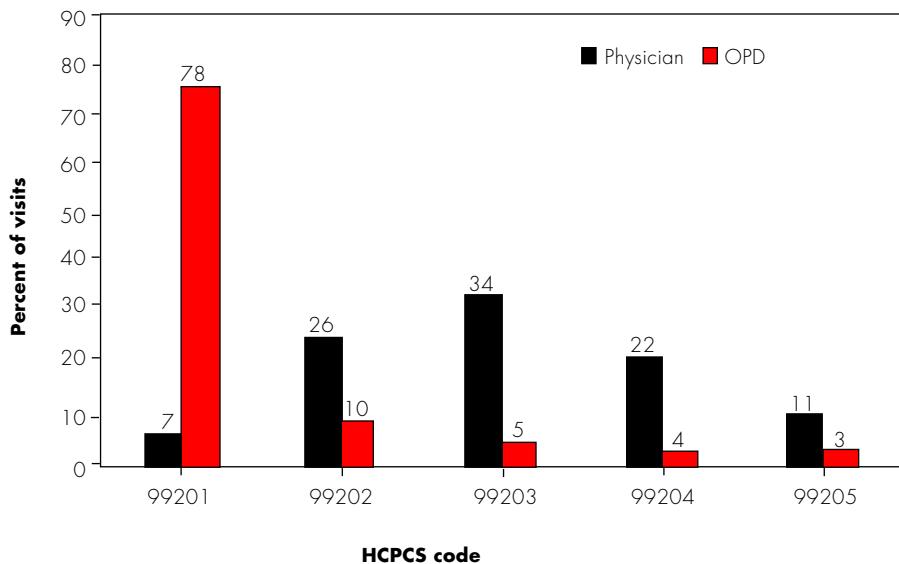
16 An update framework that included PLI expenses, in addition to practice expenses, could also be considered.

17 For purposes of illustration, this example assumes a simple update framework consisting only of an input price index and not other factors, such as case-mix change.

18 The update adjustment factor in this example assumes no change in the current statutory limit on increases in the fee schedule conversion factor. That limit is MEI plus 3 percentage points. Because the share of total physician fee schedule payments attributable to work and PLI is only 0.577, the limit becomes 5.2 percent ($3/0.577$) when applied to work and PLI.

**FIGURE
4-1**

Distribution of codes for visits by new patients to physicians and outpatient departments, 1998



Note: OPD (outpatient department), HCPCS (Health Care Financing Administration Common Procedure Coding System). OPD data are from the full year; physician data are from the first six months of the year. These HCPCS codes are used to bill for office and other outpatient visits. They are on an ascending scale that measures the providers' complexity of decisionmaking and the comprehensiveness of the history and examination.

Source: MedPAC analysis of 1998 Medicare claims, 5 percent sample of beneficiaries.

Medicare's other fee-for-service payment systems, the Congress has chosen this option for updating payments to physicians. The Congress has also given the Secretary of Health and Human Services the authority to use an expenditure target when updating payments under the new OPD PPS.

As discussed earlier, updating payments with an expenditure target is very different from updating payments with an update framework. Using an expenditure target, the focus of the update process shifts from factors influencing changes in providers' costs to issues related to spending control and the factors that should be used to determine the target. In the case of physicians' services and ambulatory care facilities, setting a target is further complicated by the goal of achieving consistency in updates across settings.

To illustrate how an expenditure target could serve as a mechanism for achieving consistency in updates for physicians' services and ambulatory care facilities, MedPAC has considered modifying the SGR system for this purpose. The Commission's work shows that modifying the SGR system to include OPDs and ASCs would be difficult. Two issues—the process for setting the target and the magnitude of the target—are important.

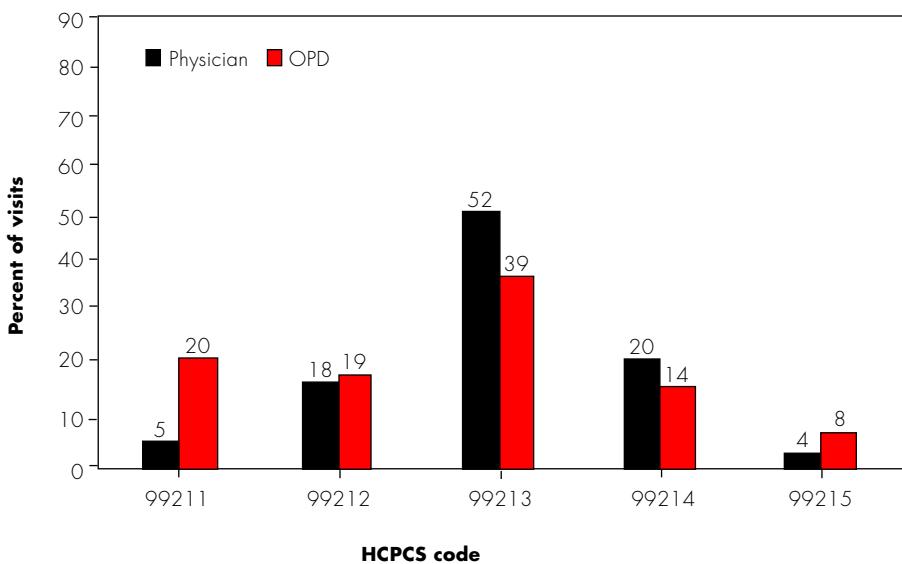
Process for setting an expenditure target An expenditure target system requires a process for setting the target. Under the SGR system, the Congress specified a formula in the BBA. It is not known whether that formula would yield an appropriate target if ambulatory care facilities were added to the system.

Under an expanded SGR system, the process for setting the target would need to accommodate shifts in the site of care from inpatient to ambulatory care settings. A service such as cholecystectomy, for example, can be provided in an inpatient setting or, in the case of a laparoscopic cholecystectomy, in an ambulatory care setting.

To illustrate the importance of shifts in the site of care, the Commission analyzed physician claims data for 1994–1998 to address two questions: Is care shifting

**FIGURE
4-2**

Distribution of codes for visits by established patients to physicians and outpatient departments, 1998



Note: OPD (outpatient department), HCPCS (Health Care Financing Administration Common Procedure Coding System). OPD data are from the full year; physician data are from the first six months of the year. These HCPCS codes are used to bill for office and other outpatient visits. They are on an ascending scale that measures the providers' complexity of decisionmaking and the comprehensiveness of the history and examination.

Source: MedPAC analysis of 1998 Medicare claims, 5 percent sample of beneficiaries.

**TABLE
4-3****Expenditure shares for high-volume physicians' services provided in inpatient and ambulatory care settings, 1994-1998**

Type of service	Percentage of 1998 physicians' services expenditures	Share of physicians' services expenditures in ambulatory care settings					Change 1994-1998	Shift to ambulatory care
		1994	1995	1996	1997	1998		
Consultations	6.2%	37.9%	39.5%	40.8%	41.9%	42.9%	5.0%	Decelerating
Routine diagnostic radiology	3.1	72.0	72.8	74.2	73.7	75.5	3.5	Accelerating
Echocardiograms	2.2	63.0	68.7	73.9	74.6	75.9	12.9	Decelerating
Electrocardiograms	2.0	75.4	76.2	77.5	78.4	79.5	4.1	Accelerating
CAT scans	1.8	68.7	69.9	71.2	71.9	72.6	3.9	Decelerating
Magnetic resonance imaging	1.5	89.3	90.0	91.0	91.3	91.0	1.7	Decelerating
Colorectal endoscopy	1.5	78.8	79.2	80.1	79.9	81.5	2.7	Accelerating
Nuclear imaging	1.4	76.3	80.1	84.0	85.9	87.5	11.2	Decelerating
Cardiac catheterization	1.1	22.6	25.4	27.4	30.4	32.3	9.7	Decelerating
Upper GI endoscopy	1.0	49.9	51.2	51.7	51.7	53.6	3.7	Accelerating
Ultrasound imaging (non-cardiac)	1.0	85.5	86.6	87.4	87.6	87.9	2.4	Decelerating
Angioplasty	0.7	3.5	3.9	4.2	5.5	7.9	4.4	Accelerating
Cholecystectomy	0.4	NA	25.7	29.9	34.5	39.4	13.7	Accelerating
Arthroscopy	0.2	85.3	87.0	88.1	88.7	91.1	5.8	Accelerating
Transurethral prostate surgery	0.2	11.4	14.7	16.4	18.9	21.1	9.7	Decelerating
Total	24.3							

Note: Data are from the first six months of each year. Ambulatory care settings include physicians' offices, hospital outpatient departments, and ambulatory surgical centers. CAT (computerized axial tomography), NA (not available), GI (gastrointestinal), Decelerating (decelerating shift to ambulatory care), Accelerating (accelerating shift to ambulatory care). A decelerating (accelerating) shift to ambulatory care means the change in share from 1997-1998 is less (greater) than the average annual change from 1994-1997. The cholecystectomy share of expenditures is not available for 1994 due to a change in the coding of laparoscopic cholecystectomy. The change in this services' share of expenditures was calculated with 1995 as the baseline. Percentages of 1998 physicians' services expenditures apply to all settings in which services are provided, not just the ambulatory care setting.

Source: MedPAC analysis of 1994-1998 Medicare physicians' services claims, 5 percent sample of beneficiaries.

from the hospital inpatient setting to ambulatory care settings? If so, are shifts accelerating or decelerating?

Excluding services generally provided in only one setting, a number of high-volume physicians' services are moving from the inpatient setting to one or more ambulatory care settings (physicians' offices, OPDs, and ASCs), although shifts in the site of care are complex and variable (Table 4-3). A rigid formula for calculating expenditure targets, such as that in the SGR system for physicians' services, is not likely to adequately accommodate such shifts. For example, from 1997 to 1998, the share of spending for cholecystectomy in ambulatory care settings grew from 34.5 percent to 39.4 percent. Other services experienced similar but smaller shifts in spending.

The shift of services to ambulatory care settings appears to be accelerating in some cases but decelerating in others. In the case of angioplasty, for example, in 1998, 2.4 percent of total spending for this service moved to ambulatory care settings, the highest increase in three years. Given that the fraction of spending for angioplasty in ambulatory care settings is low—only 7.9 percent in 1998—the shift toward ambulatory care could continue for some time. For other services, the shift toward ambulatory care settings is slowing. Magnetic resonance imaging (MRI) is a good example. In 1998, about 91 percent of spending for physicians' services associated with MRIs was attributable to use of the service in ambulatory care settings. This high fraction leaves little potential for further shifts to ambulatory care.

No one ambulatory care setting appears to be the primary recipient of services shifting from inpatient settings, although five services are experiencing relatively large shifts to ambulatory care: echocardiograms, nuclear imaging, cardiac catheterization, cholecystectomy, and transurethral prostate surgery. For these services, no one ambulatory care setting dominates in terms of spending growth (Table 4-2). For cholecystectomy and transurethral prostate surgery, all of the shift to ambulatory care is to OPDs, the only ambulatory care setting in which the services are provided. The other three services show the strongest spending growth in the office setting.

Magnitude of an expenditure target
Deciding the magnitude of the expenditure target would complicate expansion of the SGR system for

Simulating an expenditure target system for physicians' services and ambulatory care facilities

The Commission's simulations of an expenditure target system for physicians' services and ambulatory care facilities are based on estimates of baseline spending, target spending, and actual spending under current policy.

Baseline spending

For the first year, the Commission assumed \$49 billion in spending for physicians' services, \$16.7 billion for care in outpatient departments (OPDs), and \$1.1 billion for care in ambulatory surgical centers (ASCs).

Target level of spending

We assumed growth in real gross domestic product (GDP) per capita of 1.5 percent per year; growth in input costs (as would be measured by the Medicare Economic Index) of 2.0 percent; and fee-for-service enrollment growth of 0.1 percent, for a total of 3.6 percent.

We simulated target expenditures by projecting baseline expenditures forward using our estimate of the sustainable growth rate (SGR).

Comparing spending under current policy and an expenditure target

We compared our projections of spending under an expenditure target with projected spending under current policy. To estimate spending under current policy, we used growth rate projections from HCFA's Office of the Actuary (OACT).

For physicians' services, OACT projects spending growth under the physician fee schedule to average 4.6 percent annually from 1999–2009. To project spending under current policy, we applied this growth rate to our baseline spending estimate of \$49 billion.

For OPDs, OACT projects spending growth of 8.8 percent from 1999–2009.

To estimate program spending under current law over the same period, we multiplied our OPD baseline spending estimate of \$16.7 billion by 53 percent to count only program (and not beneficiary) spending in the base year. Next, we projected the resulting \$8.9 billion base amount forward using OACT's 8.8 percent growth rate.

Beneficiary spending for OPD services will not grow as quickly as program spending over the same period because of Balanced Budget Act of 1997 policies that reduce beneficiary coinsurance liability. For our simulation, we assumed annual growth in the use of OPD services of 6.5 percent. This fraction is OACT's 8.8 percent projected increase in program payments, minus 2.3 percentage points (MedPAC's hospital market basket forecast for 2000) to account for changes in input prices. We assumed beneficiary spending would grow at the same rate as service use, or 6.5 percent, and used this fraction to project beneficiary spending under current policy by applying this growth rate to the beneficiary share of baseline OPD spending: 47 percent of \$16.7 billion, or \$7.8 billion. Our estimate of total spending for OPD services was the sum of program and beneficiary spending.

For ASC services, we assumed spending would grow 12.9 percent annually under current law based on trends from 1992–1997.

Results

Assuming no expansion of the SGR to include services other than those provided by physicians, the difference between an SGR of 3.6 percent and projected growth in spending for physicians' services of 4.6 percent means that the conversion factor for the physician fee schedule will generally include a performance adjustment of -1.0 percent through 2009.¹⁹

Adding OPDs and ASCs to the SGR system, without a compensating increase in the system's expenditure target, would reduce the updates for all services in the expanded system. The difference between an SGR of 3.6 percent and projected growth of 5.6 percent in combined spending for physicians' services, OPDs, and ASCs, means that the typical update for the physician fee schedule's conversion factor would include a performance adjustment of -2.0 percent through 2009, which is 1 percentage point lower than the expected decrease without OPDs and ASCs included in the SGR system.

Assuming no change in growth of use of services for care in OPDs and ASCs, the updates for these facilities would also be affected by the difference between target and actual spending. Updates for both types of facilities would require performance adjustments that decrease payment rates by 2.0 percent.

These simulation results assume growth in OPD expenditures of 7.7 percent and growth in the total of expenditures for physicians' services, OPDs, and ASCs of 5.6 percent. Although all such growth projections are uncertain, the OPD projections are more so because of the influence OPD expenditures are expected to have during the initial years after the OPD PPS is introduced. Given this uncertainty, the Commission simulated the effects of alternative expenditure growth assumptions (Table 4-4), which ranged from 4.7 percent to 10.7 percent for OPDs and from 4.8 percent to 6.6 percent for the combination of physicians' services, OPDs, and ASCs. Under these alternative assumptions, performance adjustments would range from -1.2 percent to -3.0 percent. ■

¹⁹ The performance adjustment increases or decreases updates to the conversion factor to account for differences between actual spending and the expenditure target.

**TABLE
4-4****Simulated effects of
an expanded
sustainable growth
rate system**

Expenditure growth	Performance adjustment
4.8%	-1.2%
5.9	-2.3
6.6	-3.0

Note: Expenditure growth includes physicians' services, outpatient departments, and ambulatory surgical centers. A performance adjustment increases or decreases an update to account for actual expenditures below or above an expenditure target.

Source: MedPAC analysis.

physicians' services to include OPDs and ASCs. The target must be large enough to accommodate growth in beneficiary use of needed services, yet not so large as to permit undesirable spending growth.

The Commission has already raised questions about the SGR as it applies to physicians' services. In its March 1999 report to the Congress, the Commission

recommended revising the SGR to include an additional allowance for cost increases due to improvements in medical capabilities and advancements in scientific technology (MedPAC 1999). This change would be analogous to an S&TA adjustment under the Commission's update framework. Expanding the SGR system to include OPDs and ASCs would necessitate further review of the factors in the SGR. Spending for OPD and ASC services has been growing at rates of 9 percent or more in recent years (MedPAC 1999), but the SGRs announced for 1999 and 2000 have been -0.3 percent and 2.1 percent, respectively.

To illustrate the potential impact of using an expenditure target to determine spending both for physicians' services and ambulatory care facilities, the Commission simulated spending under an expanded SGR system over the 10-year period through 2009. Results suggest that expanding the SGR system to all ambulatory care settings would reduce payments for individual services by about 1 percent per year, or 10.5 percent over 10 years, with this reduction driven by the rapid growth of OPD and ASC spending relative to the current sustainable growth rate.

Thus, a simple expansion of the existing SGR system to include ambulatory care facilities would yield an expenditure target that is below projected spending. This finding, combined with the need to accommodate complex and variable shifts of care from inpatient to ambulatory settings, leads the Commission to conclude that an overall expenditure target for physicians' services and ambulatory care facilities would not be appropriate.

In addition, the Commission has concluded that multiple expenditure targets applicable to specific settings, such as physicians' offices, OPDs, and ASCs, are not advisable either. This conclusion is based on findings showing the potential for shifts of services among ambulatory care settings. The Secretary has the authority to establish such a target for OPDs, which would be separate from the existing one for physicians' services. However, the Commission believes that such narrowly based targets do not promote the goal of achieving consistency in payment updates among ambulatory care settings. Instead, they could lead to undesirable shifts of services among settings that are influenced by financial considerations. ■

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