REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 4 - A-05
(June 2005)

Subject: Economic Impact of Shifts in Site of Service

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Referred to: Reference Committee A
(Alfred Herzog, MD, Chair)

At the 2004 Annual Meeting, the House of Delegates adopted Resolution 106, which calls on the AMA to "study the effect on physician reimbursements of the shifting of open-ended inpatient Medicare Part A services to capped outpatient Medicare Part B services." The resolution also states "that if a study reveals that there is a significant decrease in physician reimbursement resulting from the shifting of open-ended inpatient Medicare Part A services to capped outpatient Medicare Part B services, that our AMA pursue all appropriate legislative and/or regulatory action to correct for both prior and ongoing physician losses under Medicare Part B reimbursement." The Board of Trustees referred the requested study to the Council on Medical Service for a report back to the House at the 2005 Annual Meeting.

The action called for in Resolution 106 (A-04) highlights a concern regarding physician payment that the AMA has been working on as part of its overall efforts to eliminate the flawed Medicare Sustainable Growth Rate (SGR) formula. Consistent with Policy H-390.855 (AMA Policy Database), the AMA's goal is to obtain legislation to eliminate the SGR formula. However, in addition to legislation, the AMA is pursuing a series of regulatory changes that the Centers for Medicare and Medicaid Services (CMS) can implement that will reduce the effect of the scheduled payment cuts on physicians and the cost of legislation to eliminate the SGR. These administrative fixes include removing drug spending from the SGR and recognizing new coverage decisions. The recommendations contained in this report are consistent with these administrative changes.

There are many ways in which care may shift from hospitals to physician offices. For example, the Medicare Payment Advisory Commission (MedPAC) has recently identified shifts from the hospital to physician offices that contribute to increased SGR spending on imaging services. Introduction of a new drug that may reduce the need for certain surgeries would reduce services provided in the hospital setting while increasing office-based care to prescribe and monitor the drug regimen. There also may be a number of hospital-based procedures that are being replaced with different office-based procedures. However, since such shifts cannot be tied to any of the factors currently recognized in the SGR, this report only examines shifts in the site of service among the same procedures, because these shifts could be viewed as a change in regulation and possibly recognized by CMS.

This report summarizes how the SGR formula is calculated, discusses how the shift in site of service can adversely affect physician payments under the Medicare Physician Payment Schedule, and presents several recommendations. In developing the report, the Council relied extensively on the expertise of staff within the AMA's Division of Physician Payment Policy and Systems, which provides the support to the AMA/Specialty Society RVS Update Committee (RUC), as well as economists in the AMA's Center for Health Policy Research.

1 BACKGROUND
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3 Procedures historically performed only in the hospital setting shifting to the office setting have
4 been monitored by the AMA for a number of years. The AMA has commented on the issue to
5 MedPAC and CMS repeatedly, and has pointed out to Congress that one failure of the SGR system
6 is that it does not make adjustments for changes in the site of service. The AMA also has
7 established policy on Medicare payment of office-based procedures. Policy H-400.957 states the
8 following:
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10 The AMA will: (1) encourage the Centers for Medicare and Medicaid Services (CMS) to
11 expand the extent and amount of reimbursement for procedures performed in the
12 physician's office, to shift more procedures from the hospital to the office setting, which is
13 more cost effective; (2) seek to have the RBRVS practice expense RVUs reflect the true
14 cost of performing office procedures; and (3) work with CMS to develop consistent
15 regulations to be followed by carriers that include reimbursement for the costs of
16 disposable supplies and surgical tray fees incurred with office-based procedures and
17 surgery.
18
19 Since physician Part B spending is constrained by spending caps, there is the potential that an
20 increase in the volume of services performed in physicians' offices could lead to additional
21 pressure on the Medicare conversion factor. The conversion factor transforms a relative value for a
22 service into a dollar amount under the Medicare Physician Payment Schedule. The current
23 conversion factor for 2005 is $37.8975. The additional spending examined in this report is due to
24 Medicare paying physicians at a higher rate for procedures performed in their offices as opposed to
25 performing the procedure in the hospital. The office-based physician payments are typically higher
26 than the payments received for performing procedures in the hospital because the physician-
27 incurred expenses are greater in the office setting. When procedures are performed in the hospital,
28 nursing support, supplies, and equipment are all the responsibility of the hospital, whereas for
29 office procedures these expenses are borne by physicians.
30
31 While Resolution 106 (A-04) focused on the shift of procedures from Medicare Part A to Part B, a
32 more likely scenario is a shift of procedures within Part B with an increase in spending that is
33 subject to the SGR target. Instead of hospital inpatient procedures moving directly to the physician
34 office setting, it is more likely that services provided in the hospital outpatient setting will move to
35 the office setting. Procedures performed in the hospital inpatient setting result in a Part A payment
36 to the hospital for hospital expenses, and a Part B payment to the physician. For procedures
37 performed in the hospital outpatient setting, both the physician and the hospital receive payments
38 from Part B, but the hospital payments do not count toward SGR spending. The physician receives
39 payment based on the Medicare Physician Payment Schedule and the hospital is paid based on the
40 Hospital Outpatient Prospective Payment System. Table 1 presents a listing of Medicare payments
41 according to the site of service.

Table 1 Medicare Payments According to Site of Service

Site of Service	Payments	Included in SGR Spending
Hospital Inpatient	Hospital-Part A Physician-Part B	Hospital-No Physician-Yes
Hospital Outpatient	Hospital-Part B Physician–Part B	Hospital-No Physician-Yes
Ambulatory Surgery Center (ASC)	ASC-Part B Physician–Part B	ASC-No Physician-Yes
Physician Office	Physician-Part B	Physician-Yes

SGR METHODOLOGY

The SGR methodology is comprised of a cumulative SGR target and cumulative SGR spending and it is essentially a budget for Medicare physician services where actual spending is compared to targeted spending. In an effort to control spending, the SGR system sets spending targets and adjusts physicians' payments based on how actual spending compares to the targets. Although growth in the SGR target is tied to growth in gross domestic product (GDP), it also is based on CMS estimates of expenditures for physicians' services due to changes in prices, fee-for service enrollment, and laws and regulations. GDP is used as a benchmark because it is supposed to provide a measure of how much growth in spending society can afford. The AMA has repeatedly pointed out that it does not make sense to link physician payments to the GDP, which is not related to the health care needs of Medicare patients. Medicare service use is driven by patient health needs, new technology, and public policies that encourage patients to seek care; however, physician payments are tied to changes in the overall economy which are unrelated to physician practice costs.

SGR spending is comprised of payments made to physicians for services provided to Medicare beneficiaries, as well as for services provided incident to a physician service such as diagnostic laboratory services and physician-administered drugs. Actual SGR spending is calculated from Medicare claims data. To calculate the Medicare payment update, target and actual spending are compared for each year since the inception of the system in 1998. Roughly speaking, if actual spending is less than the target amount (i.e., a surplus), then the payment update for the following year will be increased. If actual spending is greater than the target amount (i.e., a deficit), then the payment update for the following year will be reduced. Since the spending targets are cumulative, spending in excess of the target that is not offset in one year accumulates in future years until it is recouped.

Medicare Physician Payment Schedule services account for the largest share of actual SGR spending at approximately $64 billion or 83% of spending in 2003. Clinical laboratory fee schedule services accounted for 7% or $5.5 billion of actual SGR spending in 2003, and physician-administered drugs accounted for 10% or $7.5 billion of the total.

As services move from the hospital outpatient setting to the physician office setting, the physician payments increase due to the additional payments for office expenses, but the SGR target is not increased to account for this shift. Therefore, to the extent that procedures are moving into the office setting where all payments are counted as SGR spending, there will be an increase in SGR

spending without a corresponding increase in the SGR target. Although the total volume for a particular service can remain constant, as long as the percentage of services performed in the office setting increases, the net effect is increased SGR spending without an equal adjustment in the SGR target.

IMPACT OF SHIFTS IN SITE OF SERVICE ON SGR SPENDING

Medicare claims data were available from CMS that allowed AMA staff to replicate CMS's actual SGR spending figures. Data from 1998 and 2003 were compared to isolate the effect of site of service shifts on actual SGR spending.

The years 1998 and 2003 were chosen because they span the period for which the SGR was in effect and claims level data was available. During this time, CMS expanded the number of services subject to a site of service differential – physicians are paid at a higher rate when services are performed in the physician office setting than when they are performed in a facility, such as a hospital or an Ambulatory Surgery Center (ASC). This was an important development, because site of service shifts will generally have an effect on SGR spending only when there is a difference in physician payments (or the amount included in SGR spending) across settings.

Actual SGR spending increased from $50 billion in 1998 to more than $75 billion in 2003. Of this, approximately $800 million (or about 1% of current annual SGR spending) can be attributed to shifts in site of service for Medicare Physician Payment Schedule services based on a preliminary analysis of the data.

CPT code 78465 *Myocardial perfusion imaging tomographic (SPECT), multiple studies (including attenuation correction when performed), at rest and/or stress (exercise and/or pharmacologic) and redistribution and/or rest injection, with or without quantification,* as well as code 93307 *Echocardiography, transthoracic, real-time with image documentation (2D) with or without M-mode recording, complete* and code 93325 *Doppler echocardiography color flow velocity mapping,* topped the list of individual services with the largest measured site of service impacts. Diagnostic and other services that are broken into professional and technical components are particularly susceptible to SGR spending increases due to site of service shifts. Although the professional component of these services is counted in SGR spending regardless of setting, the technical component is generally counted only in SGR spending when performed in a non-facility setting such as the office. The shift of these technical component procedures from the hospital setting to the office accounted for 90% of the $800 million site of service impact from 1998 to 2003. This is a good example of how the SGR system does not accurately take into account changes in the delivery of care and is another reason why the SGR system should be eliminated.

In addition, there are recent examples that are not reflected in the current Medicare frequency data that may be an indication of future shifts. For example, this year CMS established office-based practice expense relative values for seven percutaneous endovascular codes. Historically, most of these procedures have been performed only in the hospital inpatient or outpatient setting. However, CMS responded to a request to establish new payments when these procedures are performed in a physician's office. As a result, these procedures now result in office-based payments that range from $1,606 to $3,237 more than when the procedure is performed in the hospital setting. Since these procedures are newly priced in the office setting, volume data do not exist. However, one can estimate possible impacts. For example, even if total volume for each of these procedures remains the same, but 25% of the procedures shift to the office setting, it will

1 result in almost $90 million in additional SGR spending annually. These codes are just one
2 example of what may occur in the future as other procedures begin to be performed in the office
3 setting.
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5 PROCEDURES MOVING FROM HOSPITAL INPATIENT TO HOSPITAL OUTPATIENT
6 SETTING
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8 The analysis in this report focused on procedures moving from the hospital outpatient setting to the
9 physician office setting since it is this shift that has a direct impact on SGR spending. However,
10 consistent with the spirit of Resolution 106 (A-04), there are procedures that also are moving from
11 the hospital inpatient setting to the hospital outpatient setting, which is an example of a shift from
12 Part A to Part B. AMA staff were able to identify a number of procedures that in 1995 were
13 predominately performed as inpatient procedures, but are now predominately performed as hospital
14 outpatient procedures, almost all of which are rarely performed in the physician office setting.
15 Table 2 lists several of these procedures. While this shift from hospital inpatient to hospital
16 outpatient settings did occur, it does not directly affect SGR spending and, therefore, was not a
17 focus of this report. Further, it should be noted that hospital payments do not have spending caps
18 and, therefore, a shift in the site of service from the inpatient to outpatient setting does not lead to
19 overall payment reductions as can occur with physician payment when services shift to the office
20 setting.

Table 2 Procedures Moving From Hospital Inpatient to Hospital Outpatient or ASC Setting

Code	Descriptor	1995 % Hospital Inpatient	2003 % Hospital Inpatient	1995 % Hospital Outpatient and Ambulatory Surgery Center	2003 % Hospital Outpatient and Ambulatory Surgery Center
23412	Repair of ruptured musculotendinous cuff (eg, rotator cuff) open, chronic	55	16	40	83
23420	Reconstruction of complete shoulder (rotator) cuff avulsion, chronic (includes acromioplasty)	60	24	36	75
33213	Insertion or replacement of pacemaker pulse generator only, dual chamber	69	40	30	59
33233	Removal of permanent pacemaker pulse generator	76	47	23	52
33240	Insertion of single or dual chamber pacing cardioverter-defibrillator pulse generator	85	47	15	53

DISCUSSION

While the extent of the measurable shift in Medicare site of service has only had a modest effect on SGR spending to date, the magnitude could be much greater in the future as new technologies are adopted that allow an increasing number of procedures to be performed in the physician office setting. This will increase SGR spending and place more pressure on an already tight SGR budget. As a result, the Council on Medical Service believes that in addition to pursuing legislative means to eliminate the SGR, the AMA should press CMS to consider shifts in site of service as a regulatory change whenever such changes trigger site of service differentials and lead to new practice expense relative values. Such an approach would be consistent with current AMA efforts to seek a change in the SGR formula that would significantly reduce the cost of legislation to preserve Medicare patients' access to physician services. Such a strategy also would address the more likely scenario of procedures moving from the hospital outpatient setting to the physician office setting, which does not involve a shift from Medicare Part A to Part B, but does affect SGR spending.

When procedures are newly priced in the physician office setting, this change should be interpreted as a new regulatory change that increases SGR spending and needs to be properly accounted for in the SGR law and regulation component to prevent spending for these new policies from being funded by reductions in the physician payment update. Currently, when CMS first assigns office expenses to procedures, it does not make any adjustments to the SGR target. These new assignments, resulting in an increase in Part B spending subject to the SGR target, should be recognized as a change in law and regulation. The Council believes that advocating for such an administrative change in the SGR would be consistent with other AMA proposed SGR system changes, such as removing physician-administered drug spending from the SGR system and recognizing new coverage decisions. While spending increases associated with these changes have been limited to date, over time the impact could be significant. The intent of pursuing such administrative changes to the SGR could reduce the cost of any future legislation designed to eliminate the SGR, and might also to reduce the size of the current forecasted Medicare physician payment cuts.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and the remainder of the report be filed:

1. That the AMA strongly advocate that, should the Sustainable Growth Rate (SGR) formula continue to be used, the Centers for Medicare and Medicaid Services (CMS) increase the SGR target to take into account procedures that are newly priced in the office setting, and continue to analyze the shift in site of service of these procedures to determine if the SGR target adjustments are accurate. (Directive to Take Action)

2. That the AMA reaffirm Policy H-390.855, which calls on the AMA to continue to assign a top priority to the prevention of further Medicare payment cuts due to the Sustainable Growth Rate (SGR) system and to seek replacement of the SGR system with payment updates that reflect increases in the cost of medical practice. (Reaffirm HOD Policy)

Fiscal Note: Continue to advocate to CMS at an estimated total cost of $1,112.