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Medicare Payment for Hospital-Based Physician Services

Statement of
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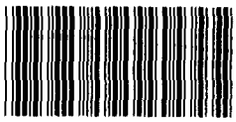
Before the
Subcommittee on Health
Committee on Ways and Means
House of Representatives



SUMMARY OF GAO TESTIMONY BY MICHAEL ZIMMERMAN ON MEDICARE PAYMENTS TO HOSPITAL-BASED PHYSICIANS

GAO was asked to answer a series of questions about three hospital-based physician specialties--radiologists, anesthesiologists, and pathologists (RAPs). These questions dealt with: (1) the contractual arrangements between hospitals and RAPs and the market structure for services provided by these physicians; (2) the level of RAP physicians' net incomes, and percentage return to medical training; (3) Medicare's controls on the volume of these physicians' services; and (4) the geographic variation in payment rates for their services.

Contractual arrangements between hospitals and RAPs. With very few exceptions, at the 16 hospitals in four states we visited, both written and verbal arrangements appeared to grant the physicians exclusive practice rights, either explicitly or in practice. We found that generally hospitals' staffing arrangements for RAPs officially were open (i.e., any physician providing RAP services could apply for medical staff privileges), but in practice only RAPs with contracts provided services. The nature of the market for RAP services provides hospitals little incentive to restrain fees when contracting for RAP services.

RAP earnings. RAPs are among the specialties with the highest net income. In addition, when physicians' net incomes were standardized for the cost of medical education, and expressed as a return on specialty training, anesthesiologists, radiologists, surgeons, and pathologists--in that order--had the highest financial return on training.

Utilization review. HCFA has no special requirements for prepayment review of RAP claims, beyond those normal for all physician services. HCFA has required reviews of office radiology services on a postpayment basis. Some carriers have initiated their own prepayment screens and postpayment studies.

Geographic variation in payment rates for selected procedures. We found considerable variation in Medicare payments across the four geographic areas we looked at. For anesthesiologists and radiologists, allowed charges for the procedures we analyzed were generally higher in Florida and Queens, New York, than in Maine and Rhode Island. For pathology allowed charges were highest in Maine and Florida.

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss the work we are doing for the Subcommittee on payments to hospital-based physicians under the Medicare program. Our testimony will focus on addressing a series of questions we were asked about three hospital-based physician specialties--radiologists, anesthesiologists, and pathologists (RAPs). These questions dealt with: (1) the contractual arrangements between hospitals and RAPs and the market structure for services provided by these physicians; (2) the level of RAP physician net income, and percentage return to medical training; (3) Medicare's controls on the volume of these physicians' services; and (4) the geographic variation in payment rates for their services.

You expressed concern that the widespread use of exclusive service contracts between hospitals and RAPs may lead to excessive fee levels and that the financial interests of the Medicare program and its beneficiaries may not be adequately represented when hospitals and physicians negotiate these exclusive arrangements.

In summary, we found that exclusive contractual arrangements between RAPs and hospitals are quite common in practice. Although these contractual arrangements can facilitate the efficient delivery of hospital services, the ones we reviewed were generally not being used by hospitals to restrain Medicare fees or limit beneficiary out-of-pocket costs. We believe that hospitals have little incentive to bargain with hospital-based physicians to restrain the physicians' charges to Medicare beneficiaries.

BACKGROUND

RAPs provide services essential to the operation of hospitals and necessary for the diagnosis and treatment of illness and injury. They are the experts in performing and interpreting the laboratory tests and X-rays other physicians need to decide how to appropriately treat patients and in administering the anesthetics necessary to perform many of those treatments. In 1985, these three hospital-based specialties accounted for 11.4 percent of the total U.S. supply of physicians and about 13.6 percent of the Medicare part B physician outlays. Radiologists, the specialty within the group with the highest level of Medicare payments, accounted for 4.5 percent of the physician supply and about 8 percent of the Medicare physician outlays.

Medicare part B payments for RAP services are generally 80 percent of the "reasonable" or "approved" charge for covered services, after the beneficiary has met the part B annual deductible of $75. The Medicare beneficiary is then responsible for paying the remaining 20 percent of the approved charge. In addition, the beneficiary is responsible for paying the difference between the amount the physician charges for the service and the approved charge, unless the physician accepts assignment. "Accepting assignment" means that the physician agrees to accept the approved charge as payment in full. Physicians have the option of becoming a Medicare participating physician, in which case they agree to accept assignment on all Medicare claims. Beginning in 1987, physicians who do not participate are subject to limitations on the maximum amount, called a maximum allowable actual charge, they can charge Medicare patients. Because of concerns the Congress has had about payment for the services of hospital-based physicians, several payment provisions apply uniquely to these physicians.

PREVALENCE OF EXCLUSIVE CONTRACTS

We were asked to review the contractual arrangements in selected geographic areas between hospitals and hospital-based physicians to assess whether the contracts granted the physicians exclusive practice rights at the hospitals or allowed for competition among physicians. With very few exceptions, at the 16 hospitals we visited, both written and verbal contractual arrangements appeared to be exclusive, either explicitly or because the contracted physicians were the only practicing physicians providing their specialty services on a recurring basis at these hospitals.

We reviewed the contractual arrangements between RAPs and hospitals in detail at four hospitals in each of the geographical areas reviewed--Maine; Rhode Island; Dade County, Florida; and Queens County, New York. At 13 of the 16 hospitals, radiologists had written contracts, while anesthesiologists had written contracts at only three hospitals. Pathologists either had written contracts or were hospital employees at all 16 hospitals.

Arrangements between physicians providing RAP services and hospitals were not standardized at the hospitals we reviewed. The written contracts included a variety of provisions, such as:

-- requiring the hospital to provide the contracting physicians the necessary equipment, supplies, and non-physician personnel;

-- giving the contracting physicians authority to operate the department, including supervising hospital employees;

-- giving exclusive use of the hospital department facilities and equipment to the contracting physicians; and

-- requiring the contracting physicians to provide enough physicians to meet the department's staffing requirements.

In an article[1] discussing a 1984 American Hospital Association survey of hospital-medical staff relationships, an exclusive contract was defined as

> ". . . a written agreement that gives a physician or physician group the right to provide administrative and clinical services in the operation of a hospital department; the agreement precludes other physicians from practicing that specialty in the hospital for the period of the contract."

The AHA survey found that about 62 percent of the pathology, 60 percent of the radiology, and 30 percent of the anesthesiology departments in the 3,601 hospitals responding had exclusive contracts in those departments.

Using the above definition of exclusive contracts, we found that nearly one-fourth of the written agreements reviewed (5 of 22) at the 16 hospitals appeared to grant the contracting physicians exclusive rights to practice their specialty at the hospital. For 15 of the 17 other written agreements, the contracted physicians were the only practicing physicians providing their specialty services at these hospitals during 1985. As a result, we believe that 20 of the 22 written agreements either explicitly stated or appeared in practice to result in exclusive arrangements. (The two exceptions were (1) a written agreement with a pathology group at one hospital that

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[1]Morrisey, M. and D. Brooks, "The Myth of the Closed Medical Staff," Hospitals, Vol. 59, No. 13 (July 1, 1985), pp. 75-77.

gave the hospital the right to select a chief pathologist from outside the pathology group and (2) a contract with a radiology group that allowed the hospital to employ radiologists outside the group. Officials at both hospitals told us that neither contract provision has been exercised.)

In addition to the written agreements, verbal agreements also appeared in practice to result in exclusive practice arrangements at most of the hospitals we reviewed with such agreements. We identified 16 verbal agreements at the hospitals surveyed. In 15 of these 16 situations, the physicians with agreements were the only physicians practicing their specialty at the hospital during 1985. In the remaining situation, an anesthesiologist outside of the contract group occasionally practiced at the hospital.

However, we noted at one of the hospitals a situation involving a verbal agreement had changed significantly since 1985. At this hospital the group of physicians who had provided anesthesia services for a number of years under a verbal agreement believed that they had an exclusive agreement. The hospital decided to hire additional anesthesiologists and was doing so at the time of our visit. The anesthesiology group contended the hospital could not hire anesthesiologists from outside their group without their consent and was litigating the matter.

HOSPITAL RAP STAFFING

We were also asked whether hospitals have open or closed staffing privileges--that is, whether the hospitals will accept new applications for staff privileges in RAP specialties. We found that hospitals' staffing arrangements for RAPs officially were open but in practice only RAPs with contracts provided services.

According to the 1984 article discussed above, a closed medical staff is defined as one where ". . . a hospital does not accept new applications for any category of medical staff privileges--either temporarily or for an indefinite period of time." Using this definition, we generally found that the 16 hospitals visited had an open staffing policy in that any physician providing RAP services could apply for medical staff privileges on the same basis as any other physician. The five hospitals, which had granted exclusive practice rights to selected RAP physicians, were the only exceptions to this open staffing policy. As a practical matter, however, the only physicians providing any RAP services on a recurring basis in our sampled hospitals during 1985 were those who had been affiliated with the contracting physicians' groups. The only exception to this was at one hospital where an anesthesiologist outside the physician group having the agreement provided some services.

EFFECTS OF EXCLUSIVE CONTRACTS AND OTHER MARKET CHARACTERISTICS ON RAP FEES

We were asked whether exclusive contracts or other characteristics of the market for hospital-based physicians result in insufficient restraint on fees. The market for RAP services has several characteristics that tend to limit the ability of market forces to restrain fees, even without exclusive contracts. In the case of exclusive contracts, although hospitals negotiate the contract provisions, they do not bear the costs of nonsalaried RAP physicians' part B services. Those costs are paid for by Medicare and its beneficiaries. Also, neither patients nor their admitting physicians typically choose hospitals based on the price of RAP services. As a result, the hospital has little incentive to negotiate low rates for the physicians' direct patient care services or the acceptance of assignment by these physicians. And few of the contracts we reviewed explicitly provided for restraint on fees or acceptance of assignment. There are, however, a number of ways that

exclusive contracts can facilitate the efficient delivery of hospital services.

By entering into an exclusive contract with physicians for the provision of RAP services, a hospital limits the ability of patients and their attending physicians to choose among competing RAPs. Once the hospital is chosen, the RAPs who will provide ancillary services are determined--i.e., the patient cannot go somewhere else for the necessary RAP services.

But, even if exclusive contracts did not exist, a number of other characteristics of the market for RAP services would tend to limit the ability of market forces to restrain fees. Individual patients and their attending physicians will typically not be very responsive to price differences among competing RAPs for a number of reasons, including:

-- the fees and the ancillary services that will be required during the hospital stay are rarely known by the patient in advance, partly because there is little repeat business;

-- the services are ancillary to the reason for admission;

-- hospital selection is typically not made on the basis of the price of RAP services; and

-- the price of the hospital-based physicians' services are typically a small fraction of the total cost of the hospital stay. (For some Medicare beneficiaries, however, the cost of hospital-based physicians' services could be a large part of their out-of-pocket cost for the hospital stay.)

In contrast, hospitals, because of their extensive and recurring dealings with RAPs, should be better situated to arrange for the informed purchase of hospital-based physician services. Hospitals have incentives to control their costs, including amounts paid to RAPs for their supervisory and managerial duties. The question is whether hospitals have incentives to bargain for part B savings for Medicare and its beneficiaries. Our work suggests that these incentives are at best weak. At the hospitals we reviewed, with two exceptions, we did not see evidence that the hospitals attempted to negotiate fees or other factors influencing patients' part B costs--though several of the written contracts did include provisions allowing the hospitals to review fees. The two exceptions involved (1) a hospital which required radiologists to accept assignment, and (2) a hospital which required radiologists to limit fees to 6 percent above prevailing charge levels.

Our review of health economics literature identified two papers that maintained that competition among hospitals for patients can encourage hospitals to negotiate fee restraints with their hospital-based physicians.[2] In essence, these papers presented the argument that hospitals would want to keep RAP fees reasonable in an effort to compete for patients. But the effectiveness of competition among hospitals for patients as it pertains to exclusive contract provisions is limited by a number of factors. As mentioned above, RAP service prices are seldom known by the patient before admission to the hospital. Further, the choice of a hospital is usually made because of the admitting physician's recommendations, the hospital's reputation in the

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[2]Lynk, W., "Restraint of Trade through Hospital Exclusive Contracts: An Economic Appraisal of the Legal Theory," Journal of Health Politics, Policy and Law, Vol. 9, No. 2 (Summer 1984), pp. 269-279 and Lynk, W. and M. Morrisey. "The Economic Basis of Hyde: Are Market Power and Hospital Exclusive Contracts Related?" Mimeographed (July 1986).

community, previous use, location, and medical staff reputation.

There are a number of ways, however, in which use of exclusive contracts can, in certain circumstances, facilitate efficient delivery of hospital services. For example, among other things, it can

-- increase the hospital's control over operation of the department;

-- lower costs through standardization of administrative procedures and centralized administration of the department;

-- permit better scheduling of the use of facilities;

-- improve the quality of services by assuring that physicians perform enough procedures to maintain their proficiency, have an incentive to upgrade their skills, and are subject to hospital standards of quality.

To the extent that these factors increase efficiency, reduced hospital costs may result.

Further, we note that in Jefferson Parish Hospital District No. 2 v. Hyde (1984), the Supreme Court reviewed for the first time issues involving hospital-physician contracts, unanimously holding that an exclusive contract between a New Orleans area hospital and a group of anesthesiologists did not violate federal antitrust law. The court held that the arrangement was not per se illegal and did not unreasonably restrain competition in actual operation.

In summary, we cannot conclude that exclusive contracts necessarily result in unrestrained fees, only that they

apparently are not being routinely used by hospitals to create restraints on fees or to require acceptance of assignment. We believe that hospitals have few incentives to use exclusive contracts to bargain with hospital-based physicians to restrain physician charges to Medicare beneficiaries.

RAP EARNINGS AND RATES OF RETURN

We were asked a series of questions dealing with the level of RAP physician earnings in comparison with other physician specialties. We found that the RAPs were among the specialties with the highest net incomes. Further, when physicians net incomes were standardized for the cost of medical education, including the length of medical specialty training, and expressed as a return on specialty training, anesthesiologists, radiologists, surgeons, and pathologists--in that order--had the highest financial return on their training.

RAPs Net Incomes are Among the Highest

RAPs earn higher net incomes than most other physicians, according to AMA data. The 1985 mean pretax net income for all physicians was $113,200. The 1985 mean pretax net income was $150,800 for radiologists, $140,200 for anesthesiologists, and $127,000 for pathologists. Compared with 1981 net income figures, the 1985 net incomes represent a 28.9 percent increase from $116,900 for radiologists, an 18.2 percent increase from $118,600 for anesthesiologists, and a 21.7 percent increase from $93,000 for all physicians. These percentage increases are greater than the percentage increase in the Consumer Price Index (CPI), which increased 17.6 percent between July 1981 and July 1985. Missing data preclude us from making a similar comparison for pathologists.

Another way of looking at RAP incomes is that, in 1985, 25 percent of all physicians earned net incomes of $140,000 or higher and 50 percent earned net incomes of $95,000 or higher. In comparison, during 1985:

-- 25 percent of the radiologists earned net incomes of $200,000 or higher, and 50 percent earned incomes of $150,000 or higher;

-- 25 percent of the anesthesiologists earned net incomes of $169,300 or higher, and 50 percent earned incomes of $128,000 or higher; and

-- 25 percent of the pathologists earned incomes of $155,000 or higher, and 50 percent earned $120,000 or higher.

Data from the Health Care Financing Administration (HCFA) on physician income in 1983 by type of employment also show evidence of high net incomes for hospital-based physicians. The four employment categories are hospital employee, clinic or health maintenance organization employee, corporate or other physician employee, and self-employed. Self-employed radiologists ($130,400), anesthesiologists ($134,100) and pathologists ($124,000) earned incomes higher than for all self-employed physicians ($99,600), with net incomes higher than all other specialties except cardiovascular disease ($130,000) and orthopedic surgery ($140,500). In the settings where the physicians were employees, for RAPs as well as for most other physician specialties, incomes were generally lower.

Rates of Return on Medical Training Are High for RAPs

In 1983, RAPs earned higher rates of return to medical education than physicians overall, according to a study funded by HCFA. Rate of return calculations are a way of comparing physicians' net earnings from medical practice, which consider the cost and length of medical training. Radiologists, anesthesiologists, and pathologists earned annual rates of return of 20, 22, and 17 percent, respectively, compared with 16 percent for all physicians. The return for surgery was 19 percent; the other specialties earned rates of return that were lower than any of the RAP specialties.

UTILIZATION REVIEW IS LIMITED

We were asked whether existing payment mechanisms provide for control on volume growth and whether these controls are effective.

To control the number of services being provided and prevent unwarranted growth, Medicare employs utilization review to prevent, identify, and recover payments for physician services that are not medically necessary. Medicare carriers, which are insurance companies used by HCFA to process physician Medicare bills, may perform these reviews on either a prepayment or postpayment basis. HCFA has no special requirements beyond those normal for all physician services for prepayment review of RAP claims. HCFA has required reviews of office radiology services on a postpayment basis.

Three of the four carriers serving the four geographic areas in our sample have developed their own prepayment screens for RAPs, and three of them performed special postpayment studies of RAP claims during the period 1983 to 1985. For example, Blue Shield of Florida developed a prepayment screen to identify

multiple anesthesia procedures for the same beneficiary on the same day. This screen reportedly enabled the carrier to save $249,241 during calendar year 1985. Florida Blue Shield also conducted a special postpayment review in 1985 of 10 Florida pathologists to determine whether pathologists were billing for clinical pathology procedures normally performed by laboratory technicians. Based on the results of this study, Florida Blue Shield is attempting to recover a total of about $59,000 from the 10 pathologists, and has established a prepayment screen to identify, for further review, claims involving more than one clinical pathology consultation per beneficiary per day.

The program savings generated by these carriers' prepayment utilization review edits are generally much more than the related costs. Carrier officials believed, however, that the potential for identifying additional questionable claims for RAP services through utilization review is limited. This is because RAP services normally are ordered by a physician other than the one providing the service, and the RAP physician is therefore generally not in a position to increase service volume.

In addition to the above utilization controls under part B, since the implementation of Medicare's hospital prospective payment system, hospitals have a strong incentive to limit ancillary services to the extent that they increase part A costs--such as the cost of administering and managing the RAP departments. This is because, under PPS, hospitals are paid a predetermined amount based on the patient's diagnosis. If services are provided for less than this amount, the hospital makes a profit. If the costs exceeded the payment, the hospital suffers a loss. Thus, PPS could be expected to exert some limiting effects on the volume of RAP services.

PAYMENT VARIES ACROSS GEOGRAPHIC AREAS

The last question we were asked to address was how Medicare reimbursement of hospital-based physicians varies across geographic areas. We found considerable variation in Medicare payments across the four geographic areas we looked at.

To answer this question, we analyzed a group of high-cost procedures, including 13 anesthesiology, 4 pathology, and 5 radiology procedures. We selected these 22 procedures because, in Rhode Island Medicare part B payment records, they accounted for at least 25 percent of the allowed charges for each type of physician.

In the four locations reviewed, the allowed charges for radiology services provided at a hospital were much lower than for the other two specialties. About 50 percent of the allowed radiology charges were for services provided at a hospital; the percentages for anesthesiology and pathology were about 96 and 70 percent, respectively. Allowed charges for radiology and anesthesiology procedures were generally higher in Florida and Queens, New York, than in Maine and Rhode Island. For pathology, allowed charges were highest in Maine and Florida.

The four carriers determined allowed charges for anesthesiology services using the same methodology. First the number of service units allowed for a given procedure was determined. (The number of service units is the sum of base units, a measure of complexity and risk, and time units, a measure of how long the procedure took.) The number of service units is then multiplied by a dollar conversion factor, which is based on physicians' past charge patterns. The product is the allowed charge for the procedure.

These allowed amounts for anesthesia varied significantly. For instance, the allowed amount for anesthesia provided during a cataract extraction with lens implantation--a common procedure for Medicare beneficiaries--varied from $285 in Queens County, New York, to $152 in Rhode Island--an 88-percent difference for the same procedure. Other common anesthesiology procedures showed considerable variation in allowed amounts, with 8 of the 13 anesthesia procedures we reviewed showing differences in the amount allowed at least as large as those for cataract extraction.

We found that different carriers use different base units in computing allowed anesthesiology charges and that this contributes to the geographic difference in payments. Because base units represent the complexity and risk of a given procedure, we believe that base unit differences for the same procedures may not be warranted.

We found significant base unit differences for 6 of the 13 procedures analyzed in the four locations reviewed. The base unit differences varied from 20 to 70 percent for the six procedures. For example, the base units for anesthesia for a "total hip replacement, simple," ranged from 7 in Florida and Rhode Island to 12 in New York. The effect of this would be to introduce a 70 percent-difference in allowed amounts across these geographic areas, all other factors being equal.

Allowed charges for pathology services were generally lower in Rhode Island and Queens, New York, where most of the pathologists were paid by the hospital for patient care.

The differences between the allowed amounts for the four pathology procedures we examined were similar to differences determined for the anesthesiology procedures. For example, in Maine and Florida, the average allowed amount was $73 and $69,

respectively, for a certain tissue analysis pathology procedure related to patients having undergone surgery, while in Rhode Island or Queens, New York, the average allowed was slightly over $46 for the same procedure.

Similarly, we found significant differences in Medicare allowed amounts for the same radiology procedures among the four carriers. For example, a radiologist in Rhode Island would receive about $31 for a two-view chest X-ray done in a physician's office, while a Queens, New York, radiologist would receive almost $44--a 42-percent difference.

In summary, these wide variations in allowed amounts raise concerns in terms of both equity and reasonableness of program payments. We will be examining this issue further in future work.

This concludes my remarks. I will be happy to answer any questions you may have.