When the Medicare Payment Advisory Commission (MedPAC) recommends, Congress eventually listens.

MedPAC is the nonpartisan government research service that provides Congress with policy suggestions to ensure Medicare funds are well spent and the program's beneficiaries have adequate access to care. Although Congress does not always immediately accept or implement MedPAC's recommendations, the commission's annual reports offer healthcare providers a look at future changes in payment policy that are bound to be on the table at some point.
This year's reports—released in March and June—are no different. They include a number of proposals that could affect payment for inpatient, outpatient, and physician services, and the June report contemplates changes to the Medicare benefit structure. Providers should understand how these proposals will affect them and develop strategies to mitigate their impact.

Medicare severity-adjusted DRG (MS-DRG) documentation and coding adjustment. MedPAC believes that recent growth in the national average case mix index is not related to an increase in the severity of the illness burden of patients seeking care, but to hospitals responding to the economic incentives embedded in the MS-DRG system to improve documentation and coding. FFY12 is the last year that the Centers for Medicare & Medicaid Services (CMS) is legally compelled to recoup alleged overpayments related to services provided in FFY08 and FFY09. However, MedPAC firmly states that CMS should recoup additional overpayments related to 2010 and 2011, which would currently require an additional estimated 2.4 percent adjustment to future market-basket updates. This change would translate into an approximately $2.4 billion additional reduction in Medicare payments for these two years alone. The odds of Congress taking action on this proposal are high, given the need for savings to reduce the deficit and offset the budgetary impact of fixing the sustainable growth rate (SGR).

Services provided by physicians acquired by hospitals. Given the recent rise in hospital acquisition of physician practices and freestanding ambulatory service centers (ASCs), the March report also expresses concern about the payment disparity for similar services provided in different outpatient delivery sites. MedPAC believes that much of this activity is due, in part, to providers' interest in taking advantage of the higher relative payment rates available through the outpatient prospective payment system (OPPS). It's no secret that once a practice gains provider-based status, it receives significantly better payment than it would under the freestanding physician fee schedule and the ASC payment system. The report doesn't advocate a specific policy solution, but MedPAC clearly sees an opportunity for significant potential savings in this area. We'll likely see formal recommendations on this topic within the next 24 months. If the savings is significant enough, congressional action will likely follow shortly thereafter.

The SGR. The challenge in replacing the SGR is in finding the money and political will to do so. The American Medical Association and other groups have been calling for Congress to include a fix as part of any debt-ceiling deal, but at the time of publication of this column, it was unlikely that Congress would do so by the August deadline. First, to simply freeze physician payments at their current levels would require at least $300 billion, which Congress clearly doesn't have. Second, there isn't a practical solution available that all stakeholders would readily embrace.
The June MedPAC report presents a range of policy ideas the commission is considering for reforming the SGR. These include:

- Overriding the current fee cuts and "establishing a few years of modest updates" to provide security and stability to providers
- Improving accuracy of time-and-intensity estimates that form the basis of physician reimbursement
- Shifting resources from procedural to cognitive services to encourage better evaluation, management, and coordination of care, particularly for those who have chronic conditions
- Making future updates contingent on the CMS secretary identifying and reducing prices for the most overpriced (and overused) services, possibly using a budget-neutral approach to support primary care payments
- Changing the payment incentives in the delivery system to reward population health management and care coordination

The last of these ideas is a longer-term goal that looks to use payment models such as bundling, medical homes, and accountable care organizations that minimize the incentive for providers to increase service volume.
Although funding for an SGR fix isn't readily available, something will have to be done within the next three years. The growing uncertainty related to physician payment cuts has not yet impeded access, but MedPAC believes that it could do so. It is highly unlikely that all of the savings necessary to reform the SGR can be found within the Medicare program. Nonetheless, the report identifies opportunities to glean some of the savings from home healthcare providers, skilled nursing facilities, and inpatient rehabilitation facilities. Even though hospitals are not specifically mentioned, it's likely that they'll contribute to the SGR fix as well.

Ancillary services. The June report has a number of recommendations affecting ancillary services. Overall, it encourages the CMS secretary to expand efforts to package more discrete services into a larger bundle for payment. Regarding diagnostic imaging, in particular, MedPAC recommends that Congress apply multiple procedural discounting to the professional component for imaging services provided by the same practitioner and reduce the physician work component of imaging and other diagnostic tests ordered and performed by the same practitioner.

The recommendation with the greatest potential impact on hospitals encourages Congress to establish a prior authorization program for practitioners who order "substantially more" advanced imaging services than do their peers. Research has shown that physicians in the top decile of imaging ordering account for 50 percent of all studies ordered. Most of these physicians are self-referring, so the impact of this change on imaging volume at hospital-owned facilities would be only marginal. Nonetheless, the change would have a downstream impact on surgical services. Research has shown a positive correlation between availability of high-end diagnostic imaging and various elective surgeries. For example, a study published in *Health Affairs* in 2009 disclosed that the number of lower-back surgeries in a given area rises with the increasing number of magnetic resonance image devices (Baras, J., and Baker, L., "Magnetic Resonance Imaging and Low Back Pain Care for Medicare Patients," *Health Affairs*, November/December 2009).

Value-based benefit design. The June MedPAC report reviews three options the commission is exploring to implement value-based benefit design. The first option involves creating an integrated deductible structure that is capped to reduce beneficiaries' exposure to catastrophic illness. However, the plan requires an increase in outpatient copayments to reduce the use of low-value, supply-sensitive services, thereby offsetting the lost revenue from the creation of a cap and generating savings for the program.

As a second option, MedPAC proposes prohibiting first-dollar Medigap coverage. According to MedPAC's June report, it is estimated that making beneficiaries responsible for the first $550 of cost sharing and limiting Medigap coverage to 50 percent of the next $4,950 of Medicare cost sharing would lower federal spending by more than $5 billion annually.

The third option involves encouraging beneficiaries to use high-value, low-cost providers and/or reduce usage of high-cost, low-value services. This shift in usage could be achieved by providing financial incentives in the form of lower out-of-pocket payments for choosing more efficient healthcare providers or higher cost sharing for services that are deemed to have marginal value.

The first two options are already central to a number of deficit reduction plans currently under consideration. These approaches not only have the potential to reduce volume for elective procedures and services, but also would require hospitals to collect more payment from beneficiaries.

The third option is at least several years from being implemented. However, it has the most significant ramifications for providers, because Medicare fee-for-service beneficiaries would, for the first time, be actively steered to low-cost, high-quality facilities. It's likely that when CMS identifies "high-value" providers, the agency will look not only at the individual costs for a hospital, but also at the program's total spend on patients who have been attributed to the hospital using a metric similar to the efficiency metric proposed in the FFY12 inpatient PPS rule.

The net effect of all three options will push Medicare beneficiaries to behave more like traditional consumers, as they eventually are provided with a powerful economic incentive to get better value for their money.

Actions for Providers

Despite the inevitable vigorous lobbying by the various organizations that represent healthcare interests in Washington against these provisions, these recommendations are likely to be accepted in some form due to the need to generate savings from Medicare to reduce the federal deficit, replace the physician SGR, and increase payment for primary care. Providers should begin preparing now by taking several steps.

First, providers should prepare for reimbursement cuts and increased consumerism by looking for opportunities to reduce cost and improve efficiency by reengineering the way care is delivered. Second, hospitals and health systems should reevaluate their physician integration plans. In the short term, they should carefully consider the impact of more stringent provider-based rules. A hospital contemplating the acquisition of freestanding physician practices and other provider types needs to ensure that these entities firmly fit into the organization's strategies for improving the value of the care it delivers. If the long-term economic justification for acquiring a practice is to obtain the payment benefits of converting a freestanding clinic into a provider-based hospital outpatient department, this strategy should be closely reevaluated to see if the acquisition still makes strategic sense in light of potential changes that could eliminate these benefits.

Longer term, as changes to the SGR reduce revenue for proceduralists and cause them to seek hospital employment, hospitals will need a well-formed view of which physician groups in the community are key to improving value. With such a perspective, they can then identify which physician groups are essential to executing the organization's mission, and thus should be acquired, and which are not a good fit.

Finally, organizations will need to improve their self-pay revenue cycle operations, particularly around point-of-service collections. As the Medicare benefit design is changed to increase cost sharing at lower dollar levels and first-dollar Medigap coverage is removed, hospitals will be forced to collect more from Medicare beneficiaries. It is essential that hospitals be able to do so efficiently and with sensitivity to patients' needs, feelings, and expectations.

Chad Mulvany is a technical director in HFMA's Washington, D.C., office, and a member of HFMA's Virginia Chapter.