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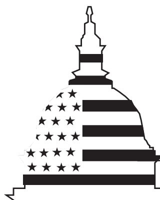
Report to Congressional Committees

September 2003

MEDICARE

Modifying Payments for Certain Pathology Services Is Warranted



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GAO-03-1056

Highlights of GAO-03-1056, a report to congressional committees

September 2003

MEDICARE

Modifying Payments for Certain Pathology Services Is Warranted

Why GAO Did This Study

In 1999, the Health Care Financing Administration, now called the Centers for Medicare & Medicaid Services (CMS), proposed terminating an exception to a payment rule that had permitted laboratories to receive direct payment from Medicare when providing technical pathology services that had been outsourced by certain hospitals. The Congress enacted provisions in the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) to delay the termination. The BIPA provisions directed GAO to report on the number of outsourcing hospitals and their service volumes and the effect of the termination of direct laboratory payments on hospitals and laboratories, as well as on access to technical pathology services by Medicare beneficiaries. GAO analyzed Medicare inpatient and outpatient hospital and laboratory claims data from 2001 to develop its estimates.

What GAO Recommends

GAO suggests that the Congress may wish to consider not reinstating the provision that allows laboratories to receive direct payment from Medicare for technical pathology services provided to hospital patients. GAO recommends that the Administrator of CMS terminate the policy of allowing laboratories to receive direct payment. CMS stated it would carefully consider our recommendation.

www.gao.gov/cgi-bin/getrpt?GAO-03-1056.

To view the full product, including the scope and methodology, click on the link above. For more information, contact A. Bruce Steinwald at (202) 512-7119.

What GAO Found

In 2001, approximately 95 percent of all Medicare prospective payment system (PPS) hospitals—hospitals that are paid predetermined fixed amounts for services—and critical access hospitals (CAH), which receive reimbursement from Medicare based on their reasonable costs, outsourced some technical pathology services to laboratories that received direct payment for those services. However, the median number of outsourced services per hospital was small—81.

If laboratories had not received direct payments for services for hospital patients, GAO estimates that Medicare spending would have been $42 million less in 2001, and beneficiary cost sharing obligations for inpatient and outpatient services would have been reduced by $2 million. Most hospitals are unlikely to experience a financial burden from paying laboratories to provide technical pathology services. If payment to the laboratory is made at the current rate, a PPS hospital outsourcing the median number of technical pathology services outsourced by PPS hospitals, 94, would incur an additional annual cost of approximately $2,900. There would be no financial impact for the 31 percent of rural hospitals that are CAHs, as they would receive Medicare reimbursement for their additional costs.

Medicare beneficiaries' access to pathology services would likely be unaffected if direct laboratory payments are terminated. Hospital officials stated they were unlikely to limit surgical services, including those requiring pathology services, because limiting these services would result in a loss of revenue and could restrict access to services for their communities.

Payments to Laboratories by Medicare and Medicare Beneficiaries for Technical Pathology Services Provided to Hospital Inpatient and Outpatients, 2001

	Dollars in millions		
	Services provided to inpatients	Services provided to outpatients	Total
Estimated Medicare payments	$18	$33	**$51**
Estimated beneficiary copayments	5	8	**$13**
Total	**$23**	**$41**	**$63[a]**

Source: CMS.

Note: GAO analysis of 2001 inpatient and outpatient claims and Medicare physician fee schedule payment and copayment rates.

[a]Total does not add due to rounding.

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Abbreviations

AHA	American Hospital Association
APC	ambulatory payment classification
BIPA	Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000
CAH	critical access hospital
CAP	College of American Pathologists
CMS	Centers for Medicare & Medicaid Services
DRG	diagnosis-related group
HCFA	Health Care Financing Administration
MPFS	Medicare physician fee schedule
NRHA	National Rural Health Association
POS	Provider of Services
PPS	prospective payment system
SNF	skilled nursing facility

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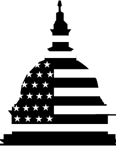

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Congressional Committees

Hospitals receive fixed, predetermined amounts under Medicare's hospital inpatient and outpatient prospective payment systems (PPS) for providing necessary services to Medicare beneficiaries. By paying hospitals fixed amounts under a PPS, Medicare seeks to encourage them to operate efficiently, as hospitals retain the difference if their payments exceed their costs of providing necessary services. Hospitals that outsource services for their patients generally pay suppliers of those services directly, and the suppliers do not receive payment from Medicare.

In 2000, the Congress enacted provisions in the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA)[1] to delay for 2 years application of a rule issued by the Health Care Financing Administration (HCFA),[2] the agency responsible for administering Medicare. The rule terminated an exception to the inpatient and outpatient PPS that permitted one type of supplier—laboratories—to receive payment directly from Medicare when providing technical pathology services[3] to beneficiaries who are hospital patients. The BIPA provisions applied only to "covered hospitals," those hospitals that had agreements with laboratories in effect as of July 22, 1999, the date HCFA proposed the rule, under which the hospitals outsourced technical pathology services to laboratories, and the laboratories received payment from Medicare for these services. Under these agreements, some hospitals may outsource all of their technical pathology services to laboratories, while others may outsource only some of their services, such as complex procedures that are rarely performed or overflow services at times of full capacity.

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[1]BIPA, Pub. L. No. 106-554, app. F, § 542, 114 Stat. 2763, 2763A-550.

[2]In July 2001, the agency's name was changed from HCFA to the Centers for Medicare & Medicaid Services. In this report, we refer to the agency as HCFA when discussing actions it took under that name.

[3]Technical pathology services involve the preparation of tissue samples removed during surgery for examination by a pathologist. Such services are performed by a laboratory technician, known as a histotechnician, and involve cutting, mounting, and staining the specimen on a microscope slide. Under Medicare, these services are referred to as the "technical component" of a pathologist's service. Medicare covers as a separate service the pathologist's examination of a specimen, which is called the "professional component."

Numerous issues were raised when HCFA issued its rule in 1999 to terminate direct Medicare payment to laboratories for technical pathology services. At the time, HCFA stated that Medicare was paying twice for those services provided to hospital inpatients, once to the hospital through the inpatient PPS payment and once to the laboratory through a separate payment.[4] In addition, outsourcing hospitals had an advantage because they did not pay the cost of technical pathology services outsourced to laboratories, while other hospitals had to pay for the cost of these services from their inpatient PPS payments.[5] Furthermore, application of Medicare cost-sharing rules resulted in added costs to inpatient beneficiaries admitted to outsourcing hospitals, compared to those for inpatients at other hospitals. Some hospitals and laboratories and their affiliated pathologists voiced concern, however, that termination of the laboratories' direct payments would increase hospitals' costs, decrease laboratories' revenues, and cause hospitals to stop performing surgical services, particularly in rural areas, reducing beneficiaries' access to services.

Although the BIPA provisions expired at the end of 2002, the Centers for Medicare & Medicaid Services (CMS) made an administrative decision to continue directly paying laboratories for technical pathology services provided to hospital patients.[6] In recent bills, both the House of Representatives and the Senate have included language to further delay application of the CMS rule.

In BIPA, the Congress directed that we report on how terminating direct laboratory payments would affect hospitals, laboratories, and access to technical pathology services by Medicare beneficiaries.[7] As agreed with the committees of jurisdiction, we (1) describe the number and type of hospitals outsourcing technical pathology services and their service volumes, (2) estimate how termination of direct laboratory payments would affect Medicare expenditures, beneficiary cost-sharing obligations, and hospital costs, and (3) examine how terminating direct laboratory

[4]HCFA's 1999 rule pertained to services delivered only to hospital inpatients because the outpatient PPS was not yet implemented. The outpatient PPS was implemented in August 2000; therefore, when the BIPA provisions were enacted in December of that year, they applied to both inpatient and outpatient services.

[5]Other hospitals either perform technical pathology services themselves or outsource and directly pay laboratories for such services.

[6]CMS Program Memorandum, Transmittal B-03-001 (Jan. 17, 2003).

[7]BIPA § 542(d), 114 Stat. 2763A-551.

payments would affect beneficiaries' access to technical pathology services in hospitals.

We used Medicare claims and provider data to identify Medicare beneficiaries receiving technical pathology laboratory services concurrently with hospital services. Using 2001 data, the most recently available, we estimated the number of urban and rural PPS hospitals and critical access hospitals (CAH),[8] which are paid their reasonable costs rather than PPS payments,[9] outsourcing technical pathology services. We also estimated the volume of and payments for these services. We relied on these data because there is no list of covered hospitals and the laboratories to which they outsource technical pathology services.

We interviewed officials at CMS, the Department of Health and Human Services Office of Inspector General, and the Congressional Budget Office, as well as representatives from several Medicare carriers.[10] In addition, we interviewed representatives from national associations representing hospitals and pathologists and representatives from 13 laboratories and 17 urban and rural PPS hospitals in eight states and an additional 2 laboratories in another state. We visited a laboratory and a rural hospital that outsources technical pathology services. We also spoke with officials from two CAHs. Our methodology is detailed in appendix I. We did our work from June 2002 through September 2003 in accordance with generally accepted government auditing standards.

[8]CAHs were created as part of a program developed to maintain access to hospital services in rural areas. In general, to be designated as a CAH, a hospital must (1) be in a rural area more than a 35-mile drive from another hospital (or certified as a necessary provider in the area), (2) make available 24-hour emergency care services, (3) have no more than 25 beds (of which no more than 15 may at any time be used for acute care to provide average acute care stays of no more than 96 hours per patient), (4) meet most Medicare requirements generally applicable to hospitals, and (5) have a quality assessment and performance improvement program, as well as procedures for utilization review. 42 U.S.C. § 1395i-4(c)(2) (2000).

[9]Reasonable cost reimbursement is based on the actual cost of providing services, including direct and indirect costs of providers, and excludes any costs that are unnecessary in the efficient delivery of services.

[10]Medicare carriers are the contractors responsible for processing claims and paying laboratories, physicians, and certain other providers.

Results in Brief

We estimate that in 2001, 4,773 PPS hospitals and CAHs, representing 95 percent of all such facilities, outsourced at least some technical pathology services to laboratories that received direct payment from Medicare for those services. In 2001, out of approximately 1.4 million outsourced technical pathology services, the median number of outsourced services per hospital was 81. Urban hospitals outsourced almost twice as many services as rural hospitals. In addition, 64 percent of these services were for outpatient beneficiaries.

If laboratories had not received direct payment for services for hospital patients, we estimate that Medicare spending would have been $42 million less in 2001, with $18 million and $24 million in savings for inpatient and outpatient services, respectively, and overall beneficiary cost sharing would have been reduced by $2 million. Comparatively, in 2001, payments to laboratories providing technical pathology services to beneficiaries who were hospital patients equaled over $63 million, including Medicare payments of about $51 million and beneficiary cost sharing of almost $13 million. Most hospitals are unlikely to experience a large financial burden from paying laboratories to provide technical pathology services. However, the extent to which an individual hospital's costs and a laboratory's revenues would change if direct laboratory payments are terminated would depend on the rates negotiated by that hospital and laboratory. If payment to the laboratory is made at the current rate, a PPS hospital outsourcing the median number of technical pathology services outsourced by PPS hospitals, 94, would incur an additional annual cost of approximately $2,900. Also, there would be no financial impact from terminating direct laboratory payments for the 31 percent of rural hospitals that are CAHs because they would be reimbursed for their costs of outsourcing technical pathology services.

Medicare beneficiaries' access to pathology services would likely be unaffected if direct payment to laboratories is terminated, as hospital representatives we spoke with stated that, because of financial and community access concerns, their hospitals were unlikely to limit surgical services, including those requiring pathology services. In addition, almost all hospital representatives we spoke with said their hospitals would likely continue to outsource technical pathology services as it would generally be less costly than performing the services themselves.

We suggest that the Congress may wish to consider not reinstating the provisions that allow laboratories to receive direct payment from Medicare for providing technical pathology services to hospital patients. We recommend that CMS terminate its policy of permitting laboratories to

receive payment from Medicare for these services. In commenting on a draft of this report, CMS stated that it is important that payment policy encourage efficiencies in the provision of technical pathology services and that it would carefully consider our recommendation. National associations that received a draft of the report for comment disagreed that direct laboratory payments should be terminated, as they believe such a change would have negative effects on beneficiaries' access to services and on rural hospitals. However, hospital representatives we spoke with said their hospitals would likely continue to outsource technical pathology services. In addition, we do not believe paying laboratories directly for these services will place a significant financial burden on rural hospitals as we estimated that the median number of technical pathology services outsourced by rural hospitals in 2001 was only 61.

Background

Medicare payment policies for technical pathology services have changed over the years as new payment systems for hospital and physician services have been implemented and modified. Beginning with the implementation of the hospital inpatient PPS on October 1, 1983, through the implementation of the Medicare physician fee schedule (MPFS) on January 1, 1992, and the outpatient PPS on August 1, 2000, payment for technical pathology services changed as fixed, predetermined payment replaced reasonable cost or charge-based reimbursement for Medicare services.

Implementation of the Inpatient PPS

Under the inpatient PPS, each inpatient stay is classifed into a diagnosis-related group (DRG) based primarily on the patient's condition. Each DRG has a payment weight assigned to it that reflects the relative cost of inpatient treatment for a patient in that group compared with that for the average Medicare inpatient. Included in the costs of each DRG are nonphysician services provided to inpatients by the hospital and its outside suppliers. A hospital receives a DRG payment from Medicare and a deductible amount from a beneficiary for each inpatient benefit period.[11] Each year, the DRG weights are recalibrated to account for changes in resource use, and the payment rate is adjusted by an update factor to account for changes in market conditions, practice patterns, and

[11]A benefit period starts with an inpatient hospital or skilled nursing facility (SNF) admission and ends after 60 consecutive days of no inpatient care. 42 C.F.R. § 409.60(a) and (b) (2002). For 2003, the deductible for each hospital inpatient benefit period is $840.

technology. Medicare separately pays physicians, including pathologists, and certain other professionals for the direct services they provide to inpatients.

When developing the inpatient PPS in the early 1980s, HCFA determined that technical pathology services outsourced to laboratories were an integral part of the professional services provided by the laboratories' pathologists, not separate nonphysician services. Based on that determination, the payment for technical pathology services provided by laboratories was included in the larger payment to the laboratories and not included in the PPS payments.[12]

Implementation of the MPFS

In 1992, HCFA implemented the MPFS, which created distinct payments for the professional and technical components of most diagnostic services, including pathology services. Although the MPFS included a distinct payment to laboratories for technical pathology services, HCFA did not revise its policy to prohibit laboratories from continuing to receive the separate Medicare payment for outsourced technical pathology services provided to inpatients. Under the MPFS, beneficiaries are responsible for a copayment equal to 20 percent of the payment for physician services, including technical pathology services. Thus, inpatient beneficiaries whose technical pathology services were outsourced by a hospital to a laboratory that received direct payment from Medicare were responsible for a copayment, while other inpatients were not.

Termination of MPFS Payments to Laboratories for Technical Pathology Services

On July 22, 1999, HCFA proposed ending Medicare payments under the MPFS to laboratories for technical pathology services provided to hospital inpatients on or after January 1, 2000.[13] Under the proposal, laboratories, like suppliers of other nonphysician services, would have to seek payment from hospitals for technical pathology services provided to hospital inpatients.

[12] In this report, we use the term "laboratory" to include both the pathology laboratory and its affiliated pathologists, as many laboratories bill Medicare for both the pathologists' professional services and the technical services.

[13] 64 *Fed. Reg.* 39,608, 39,624 (July 22, 1999).

HCFA's rationale for its proposed rule was that payment for technical pathology services provided to beneficiaries was already included in the inpatient PPS. When implementing the inpatient PPS, HCFA established separate payment rates for rural and urban hospitals based on data from hospitals' cost reports submitted to the agency. Hospitals that performed their own technical pathology services included such costs in their cost reports, while hospitals outsourcing these services did not. According to HCFA, urban hospitals generally performed such services, and in part, their higher rates reflected that. Consequently, in HCFA's view, when the separate rural rate was eliminated in 1995 and rural hospitals began receiving the higher rate paid to most urban hospitals, the cost of technical pathology services was included in that payment. Thus, HCFA concluded that when a laboratory received payment from Medicare for technical pathology services provided to a hospital inpatient, Medicare was paying twice for the same service—once to the hospital as part of the PPS payment and once to the laboratory through the MPFS. A second reason HCFA cited to support its proposed rule was concern that hospital outsourcing arrangements with laboratories to provide technical pathology services would proliferate if hospitals realized these arrangements would reduce their costs without any reduction in their inpatient PPS payments.

After considering comments from the hospital industry and laboratories, which stated, in part, that they would need additional time to renegotiate their agreements, in the final rule, HCFA delayed implementation of the policy until January 1, 2001.[14]

Temporary Continuation of Laboratories Receiving MPFS Payments

In December 2000, the Congress enacted provisions in BIPA that stated that laboratories furnishing technical pathology services to hospital patients under agreements with hospitals as of the publication date of the HCFA proposed rule could continue to receive payment directly from Medicare for these services until January 1, 2003.[15] Because the outpatient PPS was implemented in August 2000, the provisions applied to services provided to outpatients as well as inpatients.

[14]64 *Fed. Reg.* 59,380, 59,409 (Nov. 2, 1999).

[15]Although the provisions expired at the end of 2002 (BIPA § 542(c), 114 Stat. 2763A-551), CMS notified carriers that they should continue to pay laboratories separately for technical pathology services.

Implementation of the Outpatient PPS

The outpatient PPS pays hospitals a predetermined amount per service similar to a fee schedule. All services paid under the outpatient PPS, including technical pathology services, are classified into groups called ambulatory payment classifications (APC). Like inpatient DRGs, the relative weights of the APCs are adjusted annually by recalibration and the payment rates by an update factor to account for changes in resource use, technology, practice cost, and service delivery. When the outpatient PPS was implemented, beneficiary copayments for a service were generally 20 percent of the hospitals' median charges for that service in 1996, updated to 1999. Therefore, the beneficiary cost-sharing obligation as a percentage of APC payment rates varies by service. Because the median charges were often higher than the APC payment rates implemented with the outpatient PPS, beneficiary copayments were frequently as high or higher than 50 percent of the total APC payment amount. The Balanced Budget Act of 1997 established a mechanism to gradually decrease the cost-sharing percentages for all APCs to 20 percent over time.[16]

The copayments that beneficiaries are responsible for paying under the outpatient PPS for technical pathology services that are furnished directly by hospitals are roughly comparable to the copayments that beneficiaries are responsible for paying laboratories under the MPFS when services are outsourced. The outpatient PPS payment rates for technical pathology services are significantly lower than the corresponding MPFS payment rates, but outpatient PPS copayments represent a higher percentage of the payment for technical pathology services than MPFS copayments.[17]

Medicare Payment Methodologies If Direct Payments to Laboratories Are Terminated

If the BIPA provisions are not reinstated and CMS terminates direct payments to laboratories, hospitals would have to negotiate payment amounts with laboratories to pay them directly for services delivered to inpatient and outpatient beneficiaries or begin to supply these services themselves. While the hospitals would not experience any direct adjustments to their inpatient DRG payments, over time, hospital costs of

[16]Pub. L. No 105-33, § 4523(a), 111 Stat. 251, 445.

[17]For example, in 2001, the average payment rate under the outpatient PPS for the most commonly performed technical pathology service (representing approximately 56 percent of all technical pathology services outsourced by hospitals in 2001) was approximately $22, which is less than half the payment rate of approximately $51 for the same service under the MPFS. However, the copayment for that service under the outpatient PPS is approximately $12, or 54 percent, compared to approximately $10, or 20 percent, under the MPFS.

paying laboratories for technical pathology services would be reflected in the DRG weights, as the annual recalibration accounts for changes in the costs of delivering services. For services delivered to outpatients, hospitals would bill Medicare under the outpatient PPS for technical pathology services and, therefore, would recover additional revenue even if they continued to outsource these services to laboratories. Inpatient beneficiaries of hospitals that outsource technical pathology services would no longer be responsible for additional copayments to the laboratories. Outpatient beneficiaries would no longer be responsible for copayments to laboratories under the MPFS, but instead would be responsible for copayments to the hospitals where they received their services under the outpatient PPS.

CAHs, which as of March 2003 constituted 15 percent of all hospitals and 31 percent of rural hospitals, would not be affected by the termination of direct laboratory payments.[18] CAHs are not paid under the inpatient and outpatient PPS, but instead are paid based on their reasonable costs of providing services. Currently, CAHs receive no payment from Medicare for technical pathology services outsourced to laboratories that directly bill Medicare because CAHs incur no costs in the delivery of those services. If direct laboratory payments are terminated, CAHs would be reimbursed by Medicare for their costs of paying laboratories to perform technical pathology services, and outpatient beneficiaries who currently are responsible for paying 20 percent of the payment for their technical pathology services to the laboratories under the MPFS would instead be responsible for paying 20 percent of the CAHs' customary charges.[19] See table 1 for a description of Medicare payments to outsourcing PPS hospitals and CAHs, and table 2 for a description of beneficiary cost-sharing obligations at outsourcing PPS hospitals and CAHs, under current policy and if direct payment to laboratories is terminated.

[18]As of March 25, 2003, there were 749 CAHs in 44 states. The North Carolina Rural Health Research and Policy Analysis Center at the University of North Carolina estimates that as of April 15, 2003, there were an additional 69 CAH applications pending and an additional 311 rural hospitals actively considering conversion to CAH status.

[19]Medicare defines a "customary charge" as the amount that a provider charges for a specific service the majority of the time. 42 C.F.R. § 405.503(a) (2002).

Table 1: Medicare Payments for Outsourced Technical Pathology Services at PPS Hospitals and CAHs under Current Payment Policy and If Direct Payment to Laboratories Is Terminated

		PPS hospital outsources to laboratory		CAH outsources to laboratory	
		Current policy	**If direct payment is terminated**	**Current policy**	**If direct payment is terminated**
Inpatient	Hospital payment	None	None[a]	None	Reasonable costs
	Laboratory payment	MPFS payment	None[b]	MPFS payment	None[b]
Outpatient	Hospital payment	None	APC payment	None	Reasonable costs
	Laboratory payment	MPFS payment	None[b]	MPFS payment	None[b]

Source: CMS.

Note: GAO analysis of Medicare payment rules for 2003.

[a]A hospital receives a DRG payment amount for inpatient services related to the patient's condition. There is no additional payment to the hospital if direct laboratory payments are terminated.

[b]A laboratory that continues to supply these services for a hospital would receive payment directly from the hospital.

Table 2: Beneficiary Cost-Sharing Obligation for Outsourced Technical Pathology Services at PPS Hospitals and CAHs under Current Payment Policy and If Direct Payment to Laboratories Is Terminated

	PPS hospital outsources to laboratory		CAH outsources to laboratory	
	Current policy	If direct payment is terminated	Current policy	If direct payment is terminated
Inpatient	20 percent of MPFS payment to laboratory	None	20 percent of MPFS payment to laboratory	None
Outpatient	20 percent of MPFS payment to laboratory	APC copayment (percentage of payment varies by service)	20 percent of MPFS payment to laboratory	20 percent of CAH's customary charges

Source: CMS.

Note: GAO analysis of Medicare payment rules for 2003.

Few Hospitals Outsource Large Volumes of Technical Pathology Services

We estimate that in 2001, 4,773 PPS hospitals and CAHs, representing 95 percent of all such facilities, outsourced at least some technical pathology services to laboratories that received direct payment from Medicare for those services (see table 3).[20] However, most hospitals outsourced a small number of these services to laboratories. In 2001, approximately 1.4 million technical pathology services were outsourced, and the median number of outsourced services per hospital was 81. Approximately 68 percent of all hospitals outsourced 200 or fewer technical pathology services, and only 6 percent outsourced more than 1,000 services. Outsourcing hospitals consisted of 2,428 urban PPS facilities and 1,651 rural PPS facilities, representing 95 percent and 97 percent of urban and rural PPS hospitals in 2001, respectively, and 694 CAHs.

[20]We were unable to identify the number of laboratories receiving Medicare payment for technical pathology services provided to hospital patients because a single laboratory may submit claims under multiple provider numbers, and CMS does not track different provider numbers to a single laboratory.

Table 3: Number and Percentage of All Hospitals, Urban and Rural PPS Hospitals, and CAHs Outsourcing Technical Pathology Services by Number of Services in 2001

Number of services	All hospitals (percentage of total hospitals)	Urban PPS hospitals (percentage of total urban PPS hospitals)	Rural PPS hospitals (percentage of total rural PPS hospitals)	CAHs (percentage of total CAHs)
1-20	1,084 (22)	384 (15)	387 (23)	313 (42)
21-100	1,558 (31)	837 (33)	506 (30)	215 (29)
101-200	773 (15)	464 (18)	212 (12)	97 (13)
201-500	754 (15)	414 (16)	277 (16)	63 (8)
501-1,000	333 (7)	149 (6)	178 (10)	6 (1)
1,001-2,000	145 (3)	88 (3)	57 (3)	0 (0)
2,001+	126 (3)	92 (4)	34 (2)	0 (0)
Total	**4,773 (95)**[a]	**2,428 (95)**	**1,651 (97)**[b]	**694 (93)**

Source: CMS.

Note: GAO analysis of 2001 inpatient and outpatient claims and provider data.

[a]Percentage of total hospitals by number of services does not total 95 percent due to rounding.

[b]Percentage of total rural PPS hospitals by number of services does not total 97 percent due to rounding.

Among hospitals outsourcing technical pathology services, urban hospitals, including CAHs, outsourced a median of 97 services and 64 percent of all services, and rural hospitals, including CAHs, outsourced a median of 61 services and 36 percent of all services.[21] Almost twice as many services were delivered to outpatient beneficiaries compared to inpatient beneficiaries, as outpatient services accounted for approximately 64 percent of all outsourced services.

[21]Among hospitals outsourcing technical pathology services in 2001, urban hospitals outsourced approximately 892,000 services, and rural hospitals outsourced approximately 496,000 services.

Medicare Expenditures and Beneficiary Copayments Would Be Reduced, While Hospital Costs Would Increase Slightly, If Direct Payment to Laboratories Is Terminated

If laboratories had not received direct payment for services for hospital patients, we estimate that Medicare spending would have been $42 million less in 2001, with $18 million and $24 million in savings for inpatient and outpatient services, respectively, and overall beneficiary cost sharing would have been reduced by $2 million. In 2001, payments to laboratories providing technical pathology services to beneficiaries who were hospital patients equaled over $63 million, including Medicare payments of about $51 million ($18 million for inpatient services and $33 million for outpatient services) and beneficiary copayments of almost $13 million ($5 million for inpatient services and $8 million for outpatient services). Paying laboratories to provide technical pathology services is unlikely to impose a large financial burden on most hospitals. However, the extent to which an individual hospital's costs and a laboratory's revenues would change if direct payment to laboratories is terminated would depend on the rates negotiated by that hospital and laboratory. If payment to the laboratory is made at the MPFS rate, a PPS hospital outsourcing the median number of technical pathology services would incur an additional cost of approximately $2,900. Additionally, there would be no financial impact on CAHs if direct laboratory payment is terminated because they would be reimbursed for their reasonable costs of outsourcing technical pathology services.

Total Payments to Laboratories in 2001

In 2001, estimated payments to laboratories providing technical pathology services to hospital patients totaled over $63 million, including Medicare payments of about $51 million and beneficiary copayments of almost $13 million (see table 4). For services provided to inpatients, total laboratory payments equaled approximately $23 million, with $18 million from Medicare and $5 million from beneficiaries. For services provided to outpatients, total laboratory payments equaled approximately $41 million, including $33 million from Medicare and $8 million from beneficiaries.

Table 4: Estimated Payments to Laboratories by Medicare and Medicare Beneficiaries for Technical Pathology Services Provided to Hospital Inpatients and Outpatients, 2001

	Dollars in millions		
	Services provided to inpatients	Services provided to outpatients	Total
Estimated Medicare payments	$18	$33	$51
Estimated beneficiary copayments	5	8	13
Total	**$23**	**$41**	**$63**[a]

Source: CMS.

Note: GAO analysis of 2001 inpatient and outpatient claims and 2001 MPFS payment and copayment rates.

[a]Total does not add due to rounding.

Lower Medicare Payments If Direct Payment to Laboratories Is Terminated

If laboratories had not received direct payment for services for hospital patients, we estimate that Medicare spending would have been $42 million less in 2001 (see table 5). The $18 million in inpatient savings would have resulted from Medicare discontinuing payments for technical pathology services to laboratories under the MPFS, while making no additional payments to PPS hospitals for inpatient services. For outpatient services, Medicare would not have paid laboratories directly, but would have paid PPS hospitals under the outpatient PPS. If direct payment to laboratories had been terminated, Medicare would have paid PPS hospitals an estimated $9 million under the outpatient PPS in 2001 for technical pathology services, thus saving $24 million.

Table 5: Estimated Medicare Payments under Current Policy and Projected Annual Savings If Direct Payments to Laboratories Are Terminated, Based on 2001 Services

	Dollars in millions		
	Estimated payments to laboratories under current policy	Estimated payments to PPS hospitals if direct payment is terminated[a]	Projected savings after termination
Inpatients	$18	$0	$18
Outpatients	33	9	$24
Total	**$51**	**$9**	**$42**

Source: CMS.

Note: GAO analysis of 2001 inpatient and outpatient claims and MPFS and outpatient PPS payment rates.

[a]Calculations for payments if direct laboratory payment is terminated were performed for PPS hospitals only. We were unable to estimate Medicare payments to CAHs because payments depend on CAHs' reasonable costs, which vary across facilities. Total Medicare payments are likely to be higher. However, as CAHs provided less than 4 percent of all pathology services outsourced to laboratories in our analysis, we do not expect these payments to greatly increase our estimates.

Reduced Overall Beneficiary Cost Sharing

If laboratories had not received direct payment for services for hospital patients, Medicare beneficiaries would have been relieved of approximately $2 million in cost-sharing obligations (see table 6). In 2001, inpatients at hospitals that outsourced services were responsible for paying laboratories approximately $5 million in copayments under the MPFS. If direct payment to laboratories is terminated, inpatients would make no copayments to laboratories for technical pathology services. We estimate that the cost-sharing obligation of outpatients at PPS hospitals would have increased by $3 million to approximately $11 million under the outpatient PPS if laboratories had not received direct payment, compared to an estimated cost sharing of $8 million under the MPFS. However, outpatients' cost-sharing obligations for technical pathology services under the outpatient PPS gradually will decline, as mandated by the law. As the percentage declines, beneficiary copayments for technical pathology services under the outpatient PPS should become lower than under the MPFS, as long as payments for these services generally remain lower under the outpatient PPS than the MPFS.

Table 6: Estimated Beneficiary Copayments under Current Policy and Projected Annual Savings If Direct Payments to Laboratories Are Terminated, Based on 2001 Services

	Dollars in millions		
	Estimated copayments to laboratories under current policy	Estimated copayments to PPS hospitals if direct payment is terminated[a]	Projected savings after termination
Inpatients	$5	$0	$5
Outpatients	8	11	($3)
Total	**$13**	**$11**	**$2**

Source: CMS.

Note: GAO analysis of 2001 inpatient and outpatient claims and MPFS and outpatient PPS beneficiary copayment amounts.

[a]Calculations for beneficiary copayments if direct laboratory payment is terminated were performed for PPS hospitals only. We were unable to estimate the change in the cost-sharing obligations of outpatients receiving services from CAHs if direct payment to laboratories is terminated because their cost-sharing amounts depend on the CAHs' customary charges, which vary across facilities. Total beneficiary copayments are likely to be higher. However, as CAHs provided less than 4 percent of all pathology services outsourced to laboratories in our analysis, we do not expect these copayments to greatly increase our estimates.

Small Financial Effects Dependent on Negotiations

If outsourcing hospitals agree to pay laboratories the rates the laboratories currently receive under the MPFS for technical pathology services, these amounts are unlikely to impose a large financial burden on most hospitals. In 2001, a PPS hospital outsourcing the median number of services outsourced by PPS hospitals, 94, would have incurred additional costs of approximately $2,900 in paying a laboratory for technical pathology services,[22] representing a small fraction of hospitals' annual Medicare revenues.[23] A PPS hospital outsourcing 1,283 services annually—the 95th percentile of outsourced technical pathology service volume in our analysis—would have incurred an additional annual cost of just under

[22]This amount represents estimated payments to the laboratory by the hospital minus payments to the hospital for outpatient services under the outpatient PPS.

[23]According to the American Hospital Association (AHA), in 2001, the median net Medicare revenue, which is the amount actually collected by the hospital, was $30.4 million for urban hospitals and $5.6 million for rural hospitals. AHA based its estimate on an annual survey completed by community hospitals, which includes all nonfederal, short-term general and specialty hospitals whose facilities and services are available to the public.

$40,000. There would be no financial impact from terminating direct laboratory payments for rural hospitals that are or become CAHs, as CAHs would recover from Medicare their reasonable costs of outsourcing technical pathology services.

The extent to which a hospital's costs and a laboratory's revenues would change if direct laboratory payments are terminated would depend on the rates negotiated between the two parties. Hospitals' costs would increase because they would begin paying the laboratories for technical pathology services; laboratories' revenues would decline if hospitals pay lower rates for the technical pathology services than Medicare currently pays laboratories under the MPFS. Because larger hospitals and those located in urban areas have more purchasing power and may have multiple laboratories from which to choose, these hospitals are likely to fare better than smaller hospitals and those in rural areas.

Laboratory officials we spoke with voiced concern that some hospitals would insist that laboratories furnish technical pathology services at no charge or at extremely low rates in exchange for hospitals referring other business to the laboratories and their pathologists. However, these officials also indicated that their laboratories would not perform technical pathology services at no charge or for very low rates. Furthermore, hospitals might be deterred from requesting low rates because of concerns that such arrangements might violate applicable fraud and abuse laws.[24]

Although hospitals and laboratories would face new billing costs—both one-time and ongoing—if direct payments to laboratories are terminated, such changes generally would impose a modest additional cost. We spoke with officials from hospitals and laboratories that already have billing arrangements for these services, and they did not report to us that these costs were burdensome.

[24]The federal anti-kickback statute, 42 U.S.C. § 1320a-7b(b) (2000), generally prohibits knowingly and willfully providing remuneration to a referral source for the purpose of inducing referrals.

Beneficiaries' Access Likely Would Be Unaffected

Medicare beneficiaries' access to pathology services is unlikely to be disrupted if direct payments to laboratories are terminated because hospitals are unlikely to limit surgical services, including those requiring pathology services. In addition, hospitals would likely continue to outsource technical pathology services to laboratories because this would generally be less costly than performing these services themselves.

Limiting Surgeries Unlikely

Representatives of outsourcing hospitals with whom we spoke indicated that their hospitals would not eliminate or restrict surgical procedures if direct payment to laboratories is terminated.[25] Because a large percentage of hospital-based surgeries require pathology services, hospitals would lose an important source of revenue if they restricted surgeries to those not requiring such services.[26] Outsourcing hospitals stated that they could not afford this revenue loss. Rural hospitals, which are often the sole hospitals in their geographic areas, expressed the added concern that eliminating surgical procedures would reduce their communities' access to medical services.

Continuation of Outsourcing Arrangements with Laboratories

If direct payment to laboratories is terminated, representatives from hospitals that do not maintain pathology laboratories and outsource technical pathology services to laboratories said they would continue to outsource technical pathology services. Few such hospitals have a sufficiently large volume of technical pathology services to make it cost effective to perform such services themselves. For most hospitals, the equipment and personnel expenses associated with maintaining their own pathology laboratories would likely exceed the cost of outsourcing the technical pathology services to laboratories. Hospital officials also stated that they have had difficulty recruiting histotechnicians, and it therefore would be difficult to staff new, or expand existing, pathology laboratories.

[25] One Medicare carrier we spoke with shared this opinion, noting that Medicare requires SNFs to pay nonphysician providers for services and items furnished to their patients, and this requirement has not reduced beneficiary access to SNF care.

[26] A hospital risks termination from Medicare if it places restrictions on whom it will treat without exempting Medicare beneficiaries or applying the same restrictions to everyone. 42 C.F.R. § 489.53(a)(2) (2002).

Conclusions

Termination of direct laboratory payments generally would reduce Medicare expenditures and beneficiary cost-sharing obligations for technical pathology services while having little effect on beneficiaries' access to these services. While termination of direct laboratory payments would impose a small financial burden on outsourcing PPS hospitals, this change would have no impact on CAHs. As the relative payment weights of services provided under the inpatient and outpatient PPS are adjusted annually, any increased costs hospitals incur to pay laboratories for technical pathology services will, over time, be reflected in the inpatient and outpatient PPS payments. Termination of direct laboratory payments also would eliminate the inequity between beneficiary cost-sharing obligations at different hospitals.

In addition, continuing direct laboratory payments is an inappropriate means for providing financial assistance to hospitals. Hospitals, in receiving fixed payment amounts under a PPS and paying suppliers of nonphysician services provided to a Medicare patient from such fixed amounts, have an incentive to provide health care services efficiently. Permitting hospitals to outsource technical pathology services and have laboratories seek payment from Medicare eliminates the incentive for the efficient provision of these services and leads to potential Medicare double payments.

Matter for Congressional Consideration

We suggest that the Congress may wish to consider not reinstating the provisions that allow laboratories to receive direct payment from Medicare for providing technical pathology services to hospital patients.

Recommendation for Executive Action

We recommend that the Administrator of CMS terminate the policy of permitting laboratories to receive payment from Medicare for technical pathology services provided to hospital patients.

Agency Comments and Comments from National Associations and Our Evaluation

In commenting on a draft of this report, CMS stated that it is important that payment policy encourage efficiencies in the provision of technical pathology services. CMS stated that it would carefully consider our recommendation and noted that the Congress is currently considering this issue. CMS further stated that it would want to ensure that implementation of the recommendation does not adversely affect rural hospitals.

As we noted in the draft report, permitting laboratories to receive payment directly from Medicare for technical pathology services is not an appropriate or efficient mechanism for providing financial assistance to hospitals, as it is contradictory to the objectives of a PPS. In addition, because the median number of technical pathology services annually outsourced by rural hospitals was low, we do not believe that paying laboratories directly for these services will place a significant financial burden on these hospitals.

CMS's written comments are reprinted in appendix II. The agency also provided technical comments, which we incorporated where appropriate.

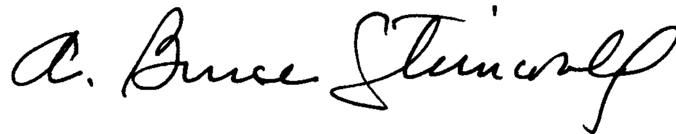
We received oral comments on a draft of this report from the American Hospital Association (AHA), the College of American Pathologists (CAP), and the National Rural Health Association (NRHA). These organizations disagreed with our conclusions, matter for congressional consideration, and recommendation and suggested that direct laboratory payments should continue. Generally, all three organizations expressed concerns about rural hospitals. AHA and NRHA expressed the concern that termination of direct laboratory payments would place a financial burden on rural hospitals, and CAP expressed concern that hospitals, including CAHs, and laboratories would experience an increased administrative burden in changing their current billing practices. CAP also raised a question about whether hospitals and laboratories would be able to successfully negotiate new payment arrangements for outsourced technical pathology services; if not, in its view, beneficiaries' access to services could be jeopardized.

As we noted in the draft report, hospital officials we spoke with, including those from rural hospitals, stated they would continue to offer technical pathology services as a part of their surgical services if they had to pay laboratories directly for technical pathology services. These officials stated that they would not consider eliminating surgeries if they had to enter new, or modify existing, arrangements with laboratories to provide technical pathology services. We acknowledge that modifying their billing practices will impose costs on hospitals and laboratories; however,

officials from hospitals and laboratories that already have billing arrangements for technical pathology services did not report to us that these costs were burdensome.

We are sending a copy of this report to the Administrator of CMS and appropriate congressional committees. The report is available at no charge on GAO's Web site at http://www.gao.gov. We will also make copies available to others on request.

If you or your staffs have any questions, please call me at (202) 512-7119 or Nancy A. Edwards at (202) 512-3340. Other major contributors to this report include Beth Cameron Feldpush, Jessica Lind, and Paul M. Thomas.



A. Bruce Steinwald
Director, Health Care—Economic
and Payment Issues

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Chairman
The Honorable Max Baucus
Ranking Minority Member
Committee on Finance
United States Senate

The Honorable W.J. “Billy” Tauzin
Chairman
The Honorable John D. Dingell
Ranking Minority Member
Committee on Energy and Commerce
House of Representatives

The Honorable William M. Thomas
Chairman
The Honorable Charles B. Rangel
Ranking Minority Member
Committee on Ways and Means
House of Representatives

Appendix I: Scope and Methodology

In conducting this study, we analyzed Medicare claims and provider data obtained from the Centers for Medicare & Medicaid Services (CMS). We interviewed officials at CMS, the Congressional Budget Office, and the Department of Health and Human Services Office of Inspector General. We also interviewed industry representatives from the American Hospital Association, College of American Pathologists, and National Rural Health Association, as well as representatives of individual hospitals and laboratories and a pathology practice management consulting company. Finally, we conducted a site visit of a laboratory and one of the rural hospitals to which it provides pathology services.

As there is no list of covered hospitals and the laboratories to which they outsource technical pathology services, we used 2001 Medicare claims data, the most recent year for which data are available, for our analysis. We received the data files directly from CMS. These data reflect the set of claims submitted to and paid by CMS for services performed in 2001. We performed our own initial analyses to check the reliability of the data.

We estimated the number of hospitals outsourcing technical pathology services to laboratories that directly billed Medicare and the volume of and payments for these services. To do so, we matched Medicare laboratory claims with claims submitted by prospective payment system (PPS) hospitals and critical access hospitals (CAH). We assumed that a laboratory's service was related to a hospital inpatient admission or outpatient encounter if the date of service on the laboratory's claim was (1) during an inpatient's stay at a hospital, within 3 days prior to the inpatient's admission,[1] or after the inpatient's discharge or (2) on the day of or within 3 days after an outpatient surgical procedure at a hospital.[2] We

[1]If a beneficiary receives diagnostic preadmission services, including pathology services, in the hospital or in an entity owned or operated by the hospital within 3 days preceding the beneficiary's admission as an inpatient, the preadmission services are included in the hospital's inpatient PPS payment. 42 C.F.R. § 412.2(c)(5) (2002). We therefore assumed that if a laboratory provided technical pathology services to a beneficiary within 3 days of the beneficiary's inpatient admission, the services were provided in connection with the beneficiary's inpatient stay.

[2]It is unlikely that a patient would receive a technical pathology service within the time period we specified that would be unrelated to the surgical services the patient received at the hospital. Nevertheless, our approach may have resulted in the inclusion of some claims for technical pathology services that were unrelated to a hospital inpatient admission or outpatient encounter, as well as the exclusion of other claims that were related. In addition, errors in the claims data, such as an incorrect discharge or encounter date, similarly could result in mistakes.

included in our list of total hospitals only those hospitals listed in the CMS Provider of Services (POS) file and characterized outsourcing hospitals as urban or rural according to their designation in the POS file. To identify hospitals outsourcing technical pathology services that have converted to CAHs, we matched each hospital's Medicare provider number to the list of CAHs maintained by the North Carolina Rural Health Research and Policy Analysis Center at the University of North Carolina as of March 2003.

To estimate Medicare payments and beneficiary copayments to laboratories for technical pathology services in 2001, we first calculated the claims frequency for each type of technical pathology service in our file of matched laboratory and hospital claims. We estimated the Medicare payment amount for each type of technical pathology service as 80 percent of the Medicare physician fee schedule (MPFS) national standard payment rate for that service and beneficiary cost sharing as the remaining 20 percent, and then we multiplied the claims frequency by the estimated Medicare and beneficiary cost-sharing amounts to calculate total laboratory payments.[3] We performed similar calculations to find payments for inpatient and outpatient claims exclusively. To estimate 2001 Medicare outpatient PPS payments and beneficiary cost sharing to PPS hospitals if laboratories had not received direct payments, we multiplied the 2001 outpatient PPS Medicare payment rate and beneficiary copayment amount for each type of technical pathology service by the frequency of each type of technical pathology service in the outpatient claims.

To estimate the cost difference to PPS hospitals of paying laboratories to perform technical pathology services, we first calculated a weighted average payment rate for technical pathology services for 2001 by multiplying the 2001 national standard MPFS payment rate by the frequency percentage of each type of technical pathology service among PPS hospitals and summing the payments for all services. We multiplied the median and 95th percentile volume of services outsourced by PPS hospitals by the estimated weighted average laboratory payment. We then calculated a weighted outpatient PPS payment rate, including beneficiary copayments, for technical pathology services in 2001 as described above for calculating the weighted average MPFS payment rate. Because approximately 63 percent of technical pathology services provided to

[3] We were unable to use the Medicare payments from the matched claims to calculate this amount because the laboratories' claims were often for both the technical and professional services, and the amounts for each could not be separated.

patients of PPS hospitals were provided to outpatients, we estimated the number of outpatient services by multiplying the median and 95th percentile volumes by 63 percent. We then multiplied the estimated number of outpatient services by the estimated weighted average outpatient PPS payment rate, and subtracted this amount from the weighted average laboratory payment.

We interviewed representatives of four Medicare carriers and four state hospitals associations. In addition, we spoke with representatives from 19 hospitals and 13 laboratories from a sample of eight geographically diverse states—Colorado, Florida, Iowa, North Dakota, Pennsylvania, Tennessee, South Dakota, and Washington—and an additional 2 laboratories in Oklahoma. We selected several states in the South, Southeast, and Midwest where, according to CMS officials, outsourcing arrangements for technical pathology services were believed to be fairly common. We interviewed officials from urban and rural hospitals and hospitals and laboratories with different types of outsourcing arrangements, including a hospital that outsources only complex and infrequently performed services and a hospital that currently pays its laboratory for technical pathology services.

Appendix II: Comments from the Centers for Medicare & Medicaid Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

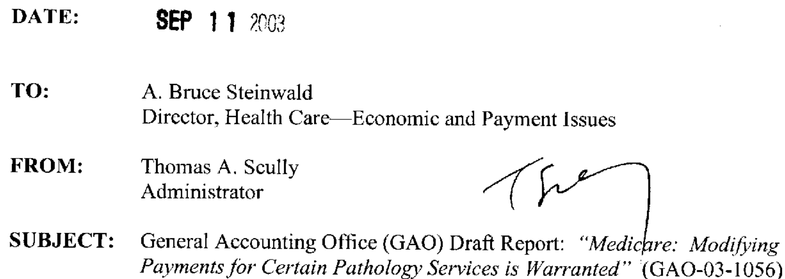
Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: SEP 11 2003

TO: A. Bruce Steinwald
Director, Health Care—Economic and Payment Issues

FROM: Thomas A. Scully
Administrator



SUBJECT: General Accounting Office (GAO) Draft Report: *"Medicare: Modifying Payments for Certain Pathology Services is Warranted"* (GAO-03-1056)

Thank you for the opportunity to review the GAO draft report entitled "*Medicare: Modifying Payments for Certain Pathology Services is Warranted*" (GAO-03-1056), in which you recommend that the Centers for Medicare & Medicaid Services (CMS) implement its 1999 proposal to change how hospitals and independent pathology laboratories bill Medicare for services to inpatients, and to apply that rule to outpatient services as well.

Under current regulations, most services, other than physician services, to hospital inpatient and outpatients are paid under prospective payment systems (PPS). Under the PPS, if services are provided to the hospital patient by a third party, the hospital is responsible for billing Medicare for those services, and for reimbursing the third party.

Historically, pathology services that are contracted out to an independent laboratory have been an exception to this rule. The independent laboratory usually bills for both the technical component (TC) and the professional component furnished by the pathologist, who is usually the owner or an employee of the laboratory.

Over the years, CMS became concerned that it was paying twice for the TC of pathology services – once to the hospital under the inpatient PPS, and once to the independent pathology laboratory. We were concerned that consulting entities were advising hospitals to outsource the TC of physician pathology services. In this way, the hospital's revenue increased because its costs were reduced. More recently CMS has become concerned that allowing independent laboratories to bill directly for the TC could leave Medicare vulnerable to billing schemes. For example, CMS has received inquiries from hospitals about the legality of leasing the hospital laboratory to a physician and whether the leased laboratory would be considered an independent pathology laboratory, capable of billing Medicare separately from the PPS for services to hospital patients.

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Therefore, in a 1999 final physician fee schedule rule, CMS proposed to require that the TC of pathology services to inpatients (the outpatient PPS had not yet been implemented) be billed by the hospital. With the implementation of the outpatient PPS in August 2000, this requirement was extended to services to hospital outpatients. However, the effective date was postponed to allow hospitals and independent laboratories to modify their contractual arrangements to comply with the new rules. Ultimately, the rule never went into effect, in part because of a moratorium imposed by Congress, pending the results of this study.

The GAO recommends that the CMS implement its final regulation published in the *Federal Register* in 1999. This final regulation would require the hospital to provide directly, or arrange for the provision of, the TC of physician pathology services. Thus, independent laboratories would no longer be able to bill the TC of physician pathology services for hospital patients.

The GAO recommendation may prove to be moot as there are currently legislative proposals to extend the exception created by section 542 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). If legislation is not enacted, we would carefully consider the GAO recommendation. However, we want to ensure the implementation of the recommendation would not adversely affect those rural hospitals whose contracted services account for a significant volume of laboratory services. It is also important that payment policy encourage efficiencies in the provision of the TC of physician pathology services.

We look forward to working with GAO on this and other issues.

(290210)

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