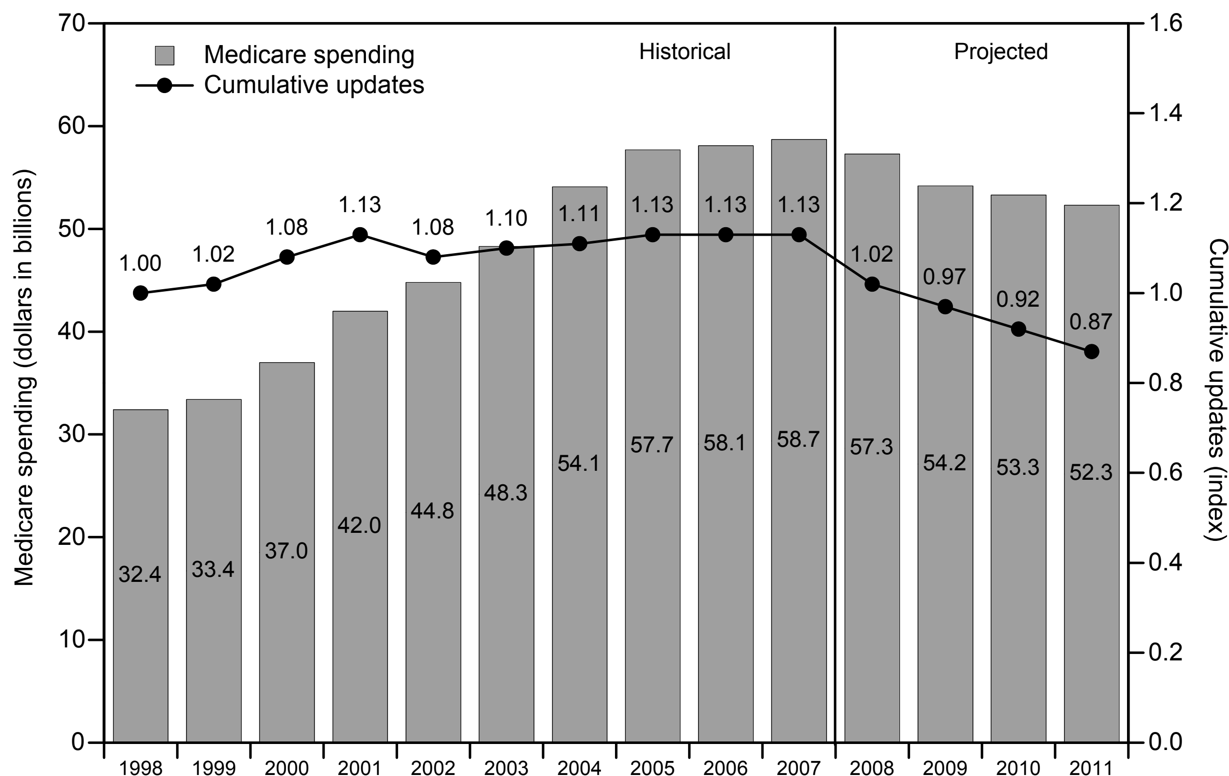
SECTION 8

Ambulatory care

Physicians
Hospital outpatient services
Ambulatory surgical centers
Imaging services

Chart 8-1. FFS Medicare spending and payment updates for physician services, 1998–2011



Note: FFS (fee-for-service). Dollars are Medicare spending only and do not include beneficiary coinsurance. The cumulative updates are presented as an index, starting from 1998 with an assigned value of 1.0. Estimates do not include the 0.5 percent payment update for physician services furnished January 1 through June 31, 2008, as established by the Medicare, Medicaid, and SCHIP Extension Act of 2007. The growth in spending was slowed in 2006 and 2007 by large increases in the number of Medicare Advantage enrollees, who are not included in these aggregate totals.

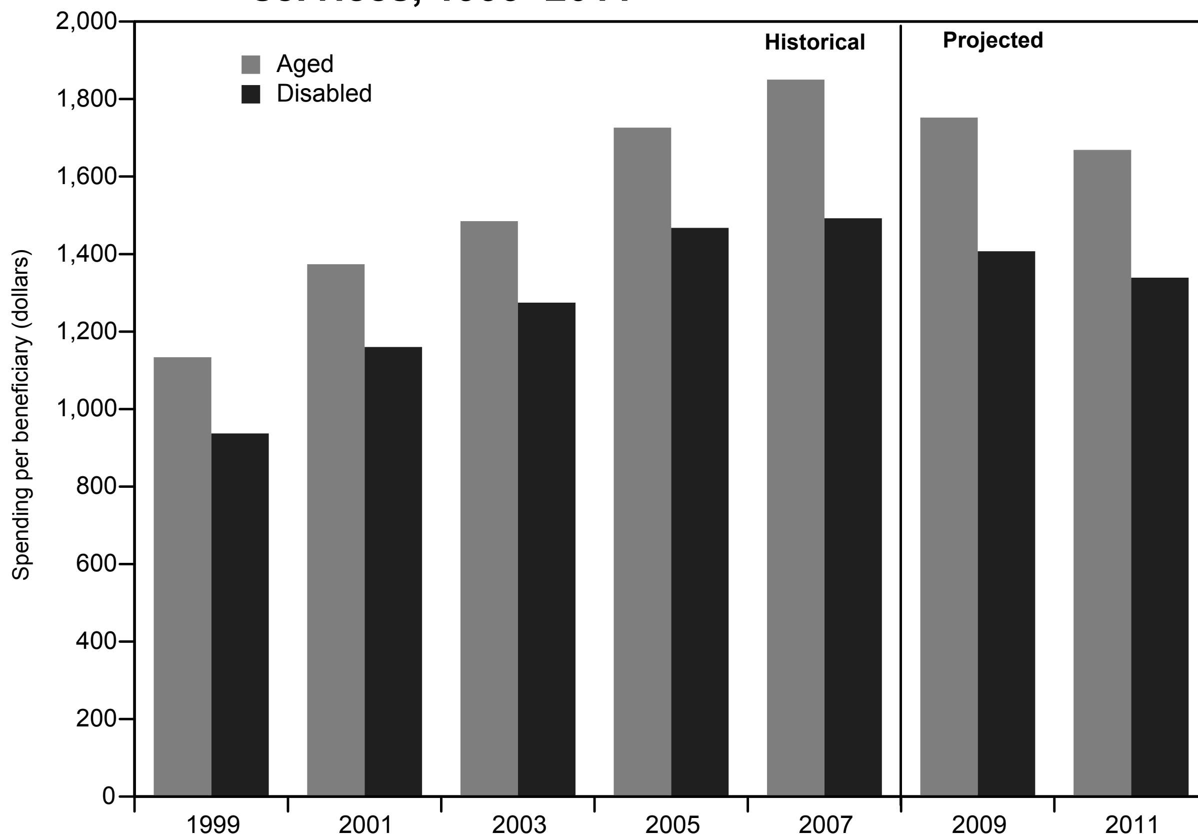
Source: 2008 annual report of the Boards of Trustees of the Medicare trust funds.

- Rapid growth in total Medicare spending on physician fee schedule services occurred between 1999 and 2005—averaging almost 10 percent annually.

- The sustainable growth rate (SGR) system requires that future payment increases for physician services be adjusted for past actual physician spending relative to a target spending level. To avoid reductions in physician fee schedule rates due to the SGR, Congress has taken several actions. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 established minimum payment updates for physician services of 1.5 percent for 2004 and 2005. For 2006, the Deficit Reduction Act froze the physician fee schedule conversion factor. This freeze, combined with refinements to the relative value units, resulted in an update of 0.2 percent for 2006. The Tax Relief and Health Care Act effectively held 2007 payments at 2006 levels through a conversion factor bonus. Most recently, the Medicare, Medicaid, and SCHIP Extension Act of 2007 updated physician services furnished January 1 through June 31, 2008, by 0.5 percent.

- As this publication goes to press, the SGR formula continues to call for payment rate cuts starting July 1, 2008, through 2016.

Chart 8-2. Medicare spending per FFS beneficiary on physician services, 1999–2011



Note: FFS (fee-for-service). Dollars are Medicare spending only and do not include beneficiary coinsurance. Estimates do not include the 0.5 percent payment increase for physician services furnished January 1 through June 31, 2008, as established by the Medicare, Medicaid, and SCHIP Extension Act of 2007. The category of "disabled" excludes beneficiaries who qualify for Medicare because they have end-stage renal disease. All beneficiaries age 65 and over are calculated within the aged category.

Source: 2008 annual report of the Boards of Trustees of the Medicare trust funds.

- Historical calculations show that fee-for-service (FFS) physician spending per beneficiary has increased annually.
- Under current law, FFS Medicare payments for physician services per beneficiary are projected to decline beginning July 1, 2008, because of scheduled negative payment updates. The volume of physician services per beneficiary, however, is expected to continue to grow.
- Per capita spending for disabled beneficiaries (under age 65) is lower than per capita spending for aged beneficiaries. In 2007, for example, per capita spending for disabled beneficiaries was $1,492 compared with $1,850 for aged beneficiaries.

Chart 8-3. Number of physicians billing Medicare is increasing steadily, 2001–2006

	Number of Medicare patients in caseload				
	≥1	≥15	≥50	≥100	≥200
Number of physicians					
2001	535,834	457,292	411,424	364,023	286,862
2002	544,615	466,299	419,269	370,144	291,593
2003	544,922	470,213	424,684	374,721	292,183
2004	561,514	483,945	440,462	393,730	315,398
2005	566,629	492,131	449,524	402,451	322,643
2006	569,461	497,072	453,822	405,504	323,877
Percent growth, 2001–2006	6.3%	8.7%	10.3%	11.4%	12.9%
Physicians per 1,000 beneficiaries					
2001	14.2	12.1	10.9	9.7	7.6
2002	14.3	12.3	11.0	9.7	7.7
2003	14.1	12.2	11.0	9.7	7.6
2004	14.4	12.4	11.3	10.1	8.1
2005	14.3	12.4	11.4	10.2	8.1
2006	14.1	12.3	11.3	10.1	8.0

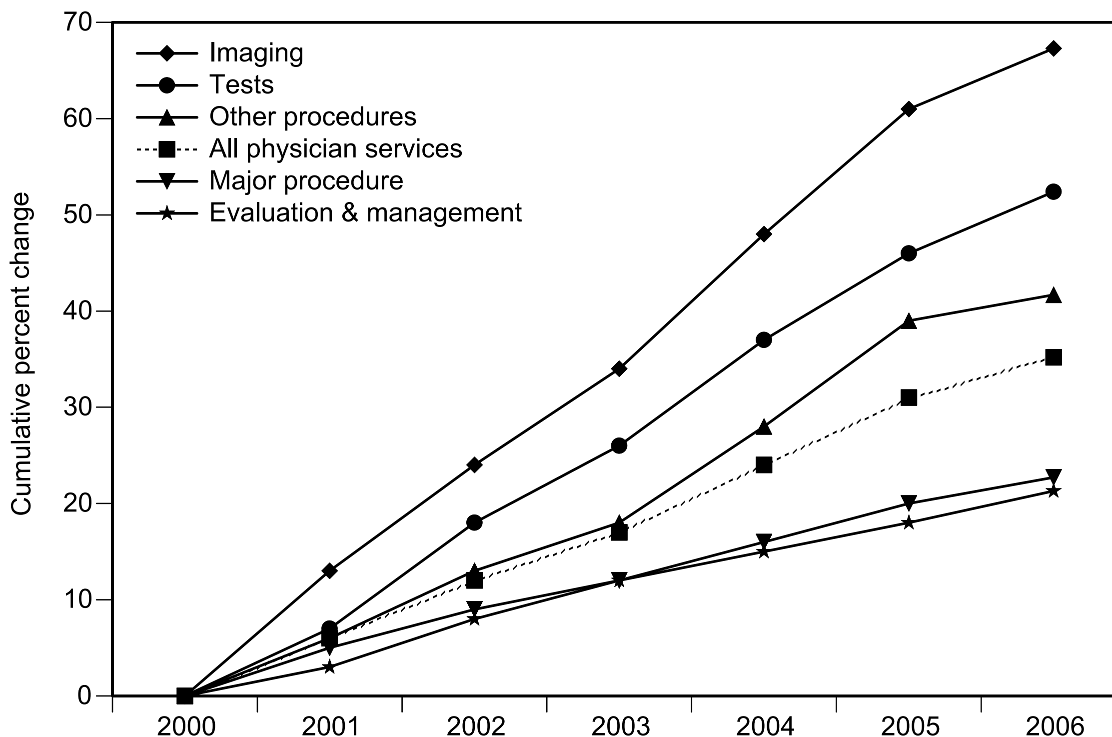
Note: Calculations include physicians (allopathic and osteopathic). Nurse practitioners, physician assistants, psychologists, and other health care professionals are not included in these calculations. Medicare enrollment includes beneficiaries in fee-for-service Medicare and Medicare Advantage, on the assumption that physicians are providing services to both types of beneficiaries. Physicians are identified by their Unique Physician Identification Number (UPIN). UPINs with extraordinarily large caseload sizes (in the top 1 percent) are excluded because they may represent multiple providers billing under the same UPIN.

Source: MedPAC analysis of Health Care Information System, CMS.

- The number of physicians providing services to beneficiaries has kept pace with growth in the beneficiary population. From 2001 to 2006, the number of physicians per 1,000 beneficiaries was relatively steady at a little over 14.

- Growth rates are faster among physicians with higher Medicare caseloads. In fact, the fastest growth is seen for physicians with caseloads of 200 or more Medicare patients. This subset of physicians grew 12.9 percent between 2001 and 2006.

Chart 8-4. Continued growth in the use of physician services per beneficiary, 2000–2006



Note: Includes only services paid under the physician fee schedule.

Source: Analysis of physician claims data for 100 percent of Medicare beneficiaries.

- Between 2000 and 2006, cumulative volume in physician fee schedule services grew about 35 percent per beneficiary. Imaging and tests grew the most, at 67 and 52 percent respectively.

- Across all services, volume grew 3.6 percent per beneficiary between 2005 and 2006. This growth rate is slightly lower then that seen in recent years. Volume for tests and imaging grew the most. From 2005 to 2006, tests grew 6.9 percent and imaging grew 6.2 percent per capita. Growth in major procedures and evaluation and management services was slower.

- Overall volume increases translate directly to growth in both Part B spending and premiums. They are also largely responsible for the negative updates required by the SGR formula.

Chart 8-5. Correlation between physicians' 2002 and 2003 efficiency scores, multilevel and Monte Carlo models

MSA	Multilevel	Monte Carlo
Boston	0.90	0.87
Greenville	0.91	0.89
Miami	0.88	0.86
Minneapolis	0.86	0.84
Orange County	0.89	0.84
Phoenix	0.90	0.88
Total	0.89	0.87

Note: MSA (metropolitan statistical area). Physicians with less than 20 episodes were excluded from the analysis. Efficiency scores are weighted by each physician's average number of episodes per year. A perfect correlation of 1.00 means that the items are at exactly the same rank in both lists. A coefficient of 0 means that there is no relationship between the rank of items on the two lists.

Source: Houchens, Robert L., Scott McCracken, William Marder, et al. Forthcoming. *The use of an episode grouper for physician profiling in Medicare.* Washington, DC: MedPAC.

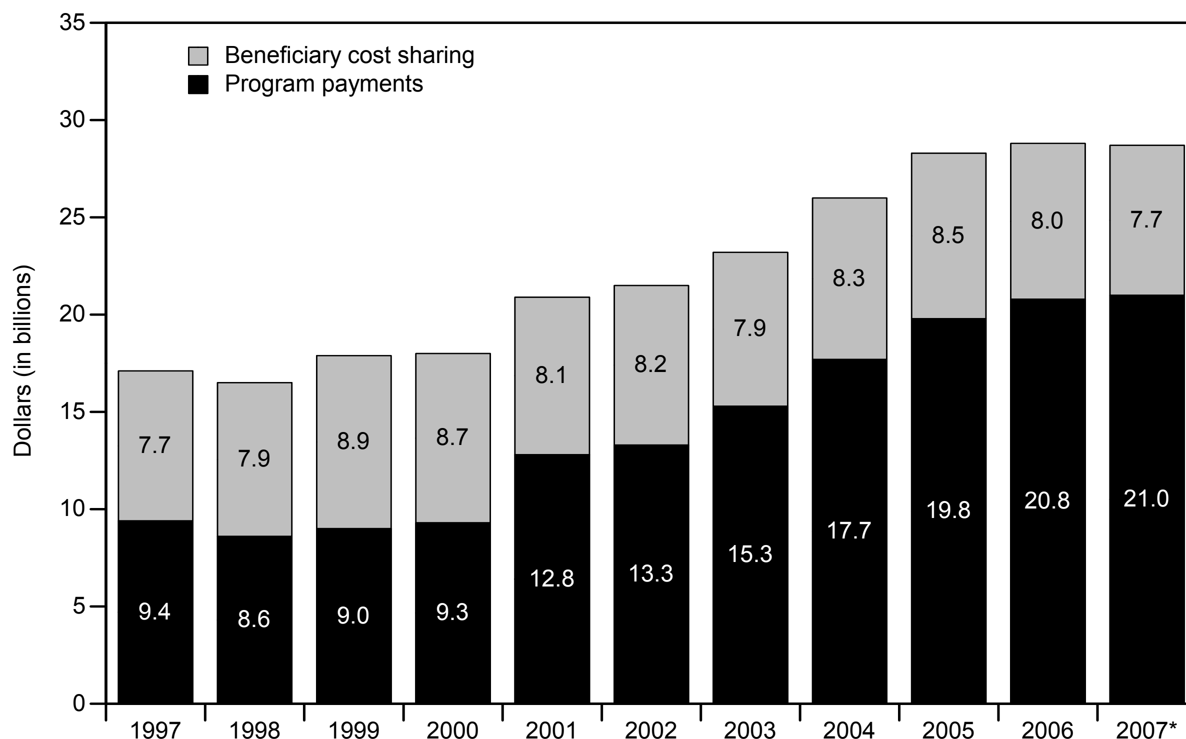
- Medicare claims were analyzed using an episode grouper to identify physicians with lower, comparable, and higher than expected utilization in the treatment of Medicare patients. To test the stability of these results, each physician's efficiency score for 2002 was compared to his or her score for 2003, using two statistical methods: multilevel regression and Monte Carlo randomization.

- Using multilevel regression, physician-level residuals (variation from the mean) form the basis for each physician's estimated efficiency score. This takes into account the correlation of episodes treated by individual physicians, unlike standard regression methods that assume physicians' episodes are uncorrelated.

- Monte Carlo randomization compares specific episode/severity/disease-stage combinations with other episodes with the same characteristics. The idea is to test whether the observed average episode payment for each physician's sample is consistent with the complete distribution of average episode payments for similar samples drawn at random from the collection of all physicians' episodes. Using this approach, physician outliers are based on how unlikely the physician's observed average episode payment is, given the distribution of average episode payments for similar samples of randomly drawn episodes.

- These correlations are quite high, indicating good year-to-year stability in the efficiency scores based on both multilevel regressions and Monte Carlo randomization. Physicians with high efficiency scores in 2002 also tended to have high scores in 2003 and vice versa.

Chart 8-6. Spending on all hospital outpatient services, 1997–2007



Note: Spending amounts are for services covered by the Medicare outpatient prospective payment system and those paid on separate fee schedules (e.g., ambulance services or durable medical equipment) or those paid on a cost basis (e.g., organ acquisition or flu vaccines). They do not include payments for clinical laboratory services. The rate of growth in spending was slowed in 2006 and 2007 by large increases in the number of Medicare Advantage enrollees, who are not included in these aggregate totals.
* Estimate.

Source: CMS, Office of the Actuary.

- Overall spending by Medicare and beneficiaries on hospital outpatient services (excluding clinical laboratory services) from calendar year 1997 to 2007 increased by 68 percent, reaching $28.8 billion. The Office of the Actuary projects continued growth in total spending, averaging 4.0 percent per year from 2004 to 2009. However, projected spending growth per beneficiary is even higher—4.7 percent—because increased enrollment in Medicare Advantage is expected to reduce the number of beneficiaries in traditional Medicare.

- A prospective payment system (PPS) for hospital outpatient services was implemented in August 2000. Services paid under the outpatient PPS represent about 91 percent of spending on all hospital outpatient services.

- In 2001, the first full year of the outpatient PPS, spending under the PPS was $19.2 billion, including $11.4 billion by the program and $7.7 billion in beneficiary cost sharing. The spending in the outpatient PPS represented 92 percent of the $20.9 billion in spending on hospital outpatient services in 2001. By 2007, spending under the outpatient PPS is expected to rise to $26.2 billion ($19.0 billion program spending; $7.2 billion beneficiary copayments). The outpatient PPS accounted for about 4 percent of total Medicare spending by the program in 2007.

- Beneficiary cost sharing under the outpatient PPS is generally higher than for other sectors, about 28 percent in 2007. Chart 8-10 provides more detail on coinsurance.

Chart 8-7. Most hospitals provide outpatient services

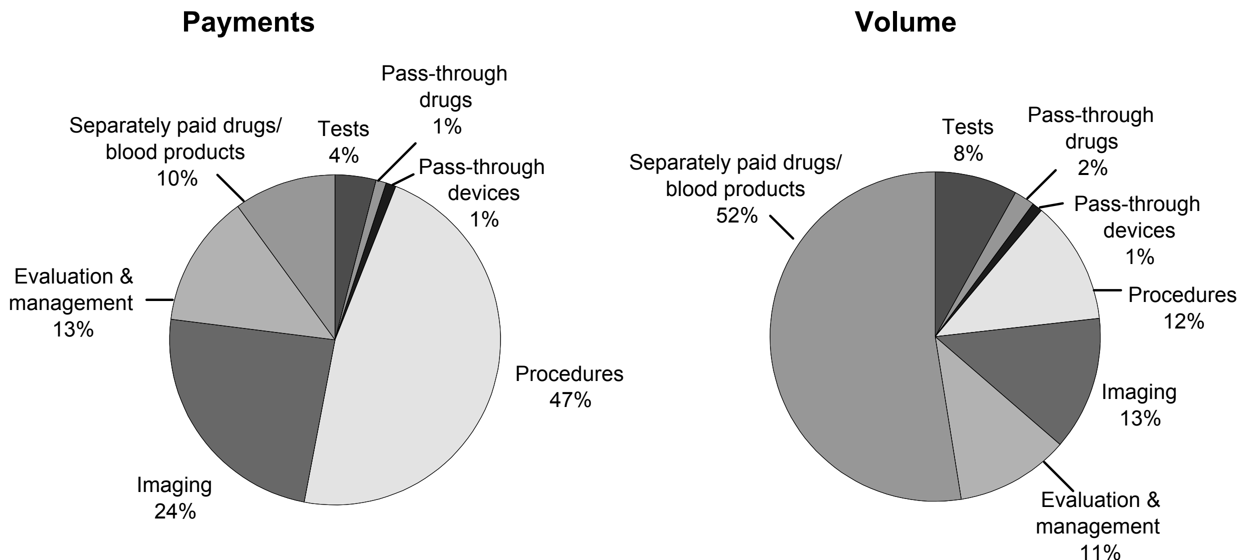
Year	Hospitals	Percent offering		
		Outpatient services	Outpatient surgery	Emergency services
1991	5,191	92%	79%	91%
1997	4,976	93	81	92
2001	4,347	94	84	93
2004	3,882	94	86	92
2007	3,638	94	87	91

Note: Includes services provided or arranged by short-term hospitals. Excludes long-term, Christian Science, psychiatric, rehabilitation, children's, critical access, and alcohol/drug hospitals.

Source: Medicare Provider of Services files from CMS.

- The number of hospitals that furnish services under Medicare's outpatient prospective payment system has declined, largely due to growth in the number of hospitals converting to critical access hospital status, which allows payment on a cost basis. However, the percent of hospitals providing outpatient services and emergency services has remained stable, and the percent providing outpatient surgery has increased.
- Almost all hospitals in 2007 provide outpatient (94 percent) and emergency (91 percent) services. The vast majority (87 percent) provide outpatient surgery.
- The share of hospitals providing outpatient services did not change after the introduction of the outpatient prospective payment system in 2000.

Chart 8-8. Payments and volume of services under the Medicare hospital outpatient PPS, by type of service, 2006



Note: PPS (prospective payment system). Payments include both program spending and beneficiary cost sharing but do not include transitional corridor payments (see Chart 8-11 for further information regarding transitional corridor payments). Services are grouped into evaluation and management, procedures, imaging, and tests, according to the Berenson-Eggers Type of Service classification developed by CMS. Pass-through drugs and separately paid drugs and blood products are classified by their payment status indicator. Percentages may not sum to 100 percent due to rounding.

Source: MedPAC analysis of the 100 percent special analytic file of outpatient PPS claims for 2006 from CMS.

- Hospitals provide many different types of services in their outpatient departments, including emergency and clinic visits, imaging and other diagnostic services, laboratory tests, and ambulatory surgery.
- The payments for services are distributed differently than volume. For example, procedures account for 47 percent of the payments, but 12 percent of the volume.
- Procedures (e.g., endoscopies, surgeries, skin and musculoskeletal procedures) account for the greatest share of payments on services (47 percent), followed by imaging services (24 percent), and evaluation and management (13 percent).
- In 2006, separately paid drugs and blood products accounted for 10 percent of payments.
- The volume of separately paid drugs and blood products grew substantially from 2005 to 2006. This is due primarily to radiologic contrast materials being separately paid in 2006, while being packaged with the associated imaging service in 2005.

Chart 8-9. Hospital outpatient services with the highest Medicare expenditures, 2006

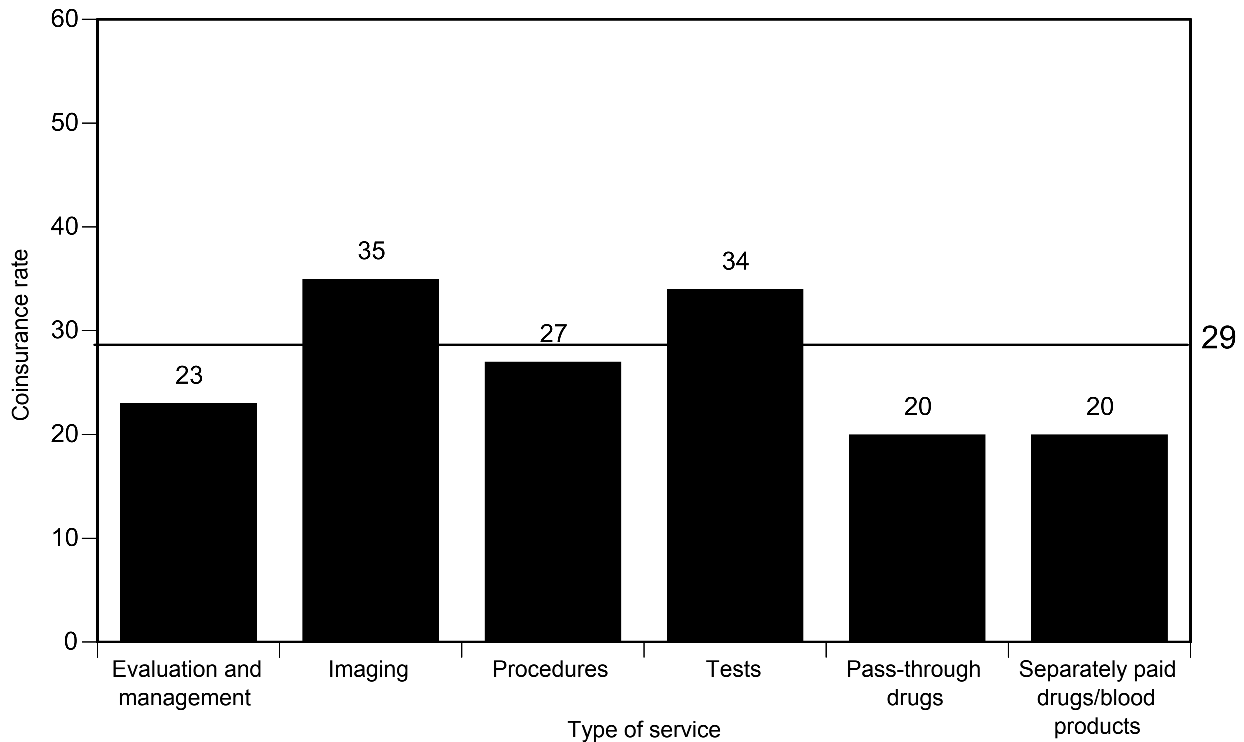
APC title	Share of payments	Volume (thousands)	Payment rate
Total	46%		
All emergency visits	7	11,290	$153
All clinic visits	4	15,768	63
Cataract procedures with IOL insert	3	631	1,388
Computerized axial tomography with contrast material	3	3,416	255
Diagnostic cardiac catheterization	3	409	2,163
Level I plain film except teeth	3	16,307	43
Lower gastrointestinal endoscopy	3	1,327	509
Computerized axial tomography and computerized angiography without contrast material	3	3,839	188
MRI and magnetic resonance angiography without contrast material followed by contrast material	2	899	506
MRI and magnetic resonance angiography without contrast material	2	1,229	349
Level II radiation therapy	1	2,731	131
Level I upper gastrointestinal procedures	1	897	480
Level III angiography and venography except extremity	1	287	1,215
Infusion therapy except chemotherapy	1	3,057	121
Computerized axial tomography and computerized angiography without contrast material followed by contrast material	1	907	304
Level II laparoscopy	1	117	2,562
IMRT treatment delivery	1	936	319
Level III nerve injections	1	810	358
Level III cardiac imaging	1	616	397
Non-coronary angioplasty or atherectomy*	1	115	2,515
Rituximab cancer treatment*	1	493	463
Hernia/Hydrocele procedures*	1	149	1,705
Average APC		411	81

Note: APC (ambulatory payment classification), IOL (intraocular lens), IMRT (intensity-modulated radiation therapy). The payment rates for “All emergency visits” and “All clinic visits” are weighted averages of payment rates from three APCs.
* Did not appear on the list for 2005.

Source: MedPAC analysis of 100 percent analytic file of outpatient prospective payment system claims for calendar year 2006.

- Although the outpatient prospective payment system covers thousands of services, expenditures are concentrated in a handful of categories that have high volume, high payment rates, or both.

Chart 8-10. Medicare coinsurance rates, by type of hospital outpatient service, 2006



Note: Services were grouped into categories of evaluation and management, imaging, procedures, and tests according to the Berenson-Eggers Type of Service classification developed by CMS. Pass-through drugs and separately paid drugs and blood products are classified by their payment status indicators.

Source: MedPAC analysis of 2006 outpatient prospective payment system claims that CMS used to set payment rates for 2008.

- Historically, beneficiary coinsurance payments for hospital outpatient services were based on hospital charges, while Medicare payments were based on hospital costs. As hospital charges grew faster than costs, coinsurance represented a large share of total payment over time.

- In adopting the outpatient prospective payment system, the Congress froze the dollar amounts for coinsurance. Consequently, beneficiaries' share of total payments will decline over time.

- The coinsurance rate is different for each service. Some services, such as imaging, have very high rates of coinsurance—35 percent. Other services, such as evaluation and management, have coinsurance rates of 23 percent.

- In 2006, the overall coinsurance rate was about 29 percent.

- The coinsurance rate for imaging dropped substantially from 2005 to 2006 because of a drop in the maximum allowed coinsurance rate from 45 percent to 40 percent and because many X-ray services had sharp declines in coinsurance.

Chart 8-11. Transitional corridor payments as a share of Medicare hospital outpatient payments, 2004–2006

	2004		2005		2006	
Hospital group	Number of hospitals	Share of payments from transitional corridors	Number of hospitals	Share of payments from transitional corridors	Number of hospitals	Share of payments from transitional corridors
All hospitals	3,495	0.8%	3,355	0.4%	3,260	0.3%
Urban	2,413	0.4	2,385	0.1	2,314	0.0
Rural ≤ 100 beds	823	5.4	709	4.7	693	2.7
Rural >100 beds	268	0.6	260	0.4	251	0.3
Major teaching	283	0.8	279	0.0	272	0.0
Other teaching	770	0.3	753	0.1	723	0.0
Nonteaching	2,441	1.3	2,323	0.9	2,264	0.5

Note: A small number of hospitals could not be classified due to missing data. Transitional corridor payments for most hospitals expired on December 31, 2003.

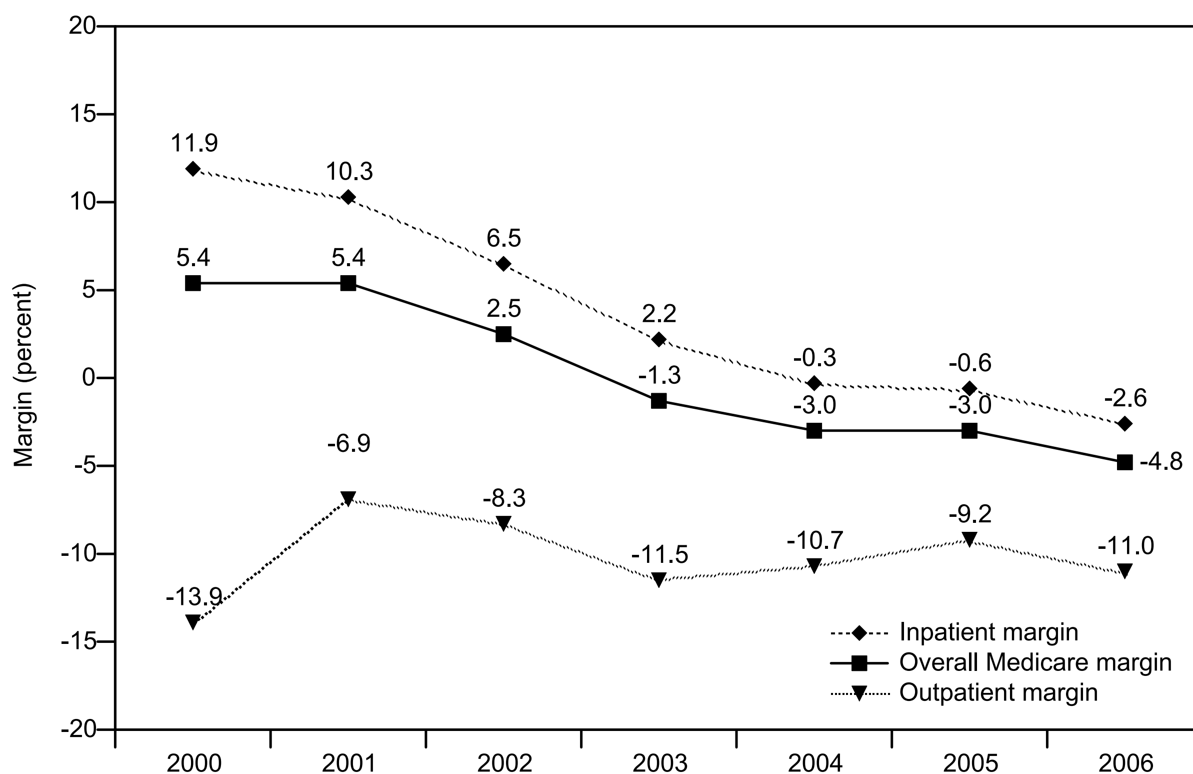
Source: MedPAC analysis of Medicare Cost Report files from CMS.

- When Medicare implemented the hospital outpatient prospective payment system (PPS) in 2000, Medicare moved from paying hospitals based on their costs to a fee schedule based on average (median) costs for all hospitals.

- Recognizing that some hospitals might receive lower payments under the outpatient PPS than they had under the earlier system, the Congress included a transition mechanism, called transitional corridor payments. The corridors were designed to make up part of the difference between payments that hospitals would have received under the old payment system and those under the new outpatient PPS. (To provide incentives for efficiency, Medicare did not compensate the full difference, except for rural hospitals with 100 or fewer beds, cancer hospitals, and children's hospitals.)

- Transitional corridor payments represented 0.8 percent of total outpatient PPS payments in 2004, declining to 0.4 percent in 2005, then to 0.3 percent in 2006. Transitional corridor payments expired for most hospitals on December 31, 2003. However, the payments continued for two more years—through December 31, 2005—for rural sole community hospitals and other rural hospitals with 100 or fewer beds. The Deficit Reduction Act of 2005 extended most of the transitional corridor payments for rural hospitals with 100 or fewer beds through December 31, 2008. In 2006, rural hospitals with 100 or fewer beds received 2.7 percent of their payments from transitional corridor payments.

Chart 8-12. Medicare hospital outpatient, inpatient, and overall Medicare margins, 2000–2006



Note: A margin is calculated as revenue minus costs, divided by revenue. Data are based on Medicare-allowable costs. Analysis excludes critical access hospitals. Overall Medicare margins cover the costs and payments of hospital inpatient, outpatient, psychiatric and rehabilitation (not paid under the prospective payment system), skilled nursing facilities, and home health services, as well as graduate medical education.

Source: MedPAC analysis of Medicare cost report data from CMS.

- Hospital outpatient margins vary. In 2006, while the aggregate margin was –11.0 percent, 25 percent of hospitals had margins of –21.6 percent or lower, and 25 percent had margins of –0.2 percent or higher.

- Given hospital accounting practices, margins for hospital outpatient services must be considered in the context of Medicare payments and hospital costs for the full range of services provided to Medicare beneficiaries. Hospitals allocate overhead to all services, so we generally consider costs and payments overall.

- The improvement in outpatient margins from 2000 to 2001 is consistent with policies implemented under the outpatient prospective payment system that increased payments. Margins declined from 2001 to 2003. This may reflect the decline in the number of drugs and devices eligible for pass-through payments. The margin improved in 2004 and 2005, which was fueled, at least in part, by many drugs becoming specified covered outpatient drugs. In 2004 and 2005, these drugs were paid on the basis of average wholesale price, which increased their payment rates. These additional payments were not budget neutral, so aggregate outpatient payments increased. The margin declined in 2006, reflecting a change that paid for these drugs on the basis of average sales price rather than average wholesale price.

Chart 8-13. Number of Medicare-certified ASCs increased over 60 percent, 2000–2007

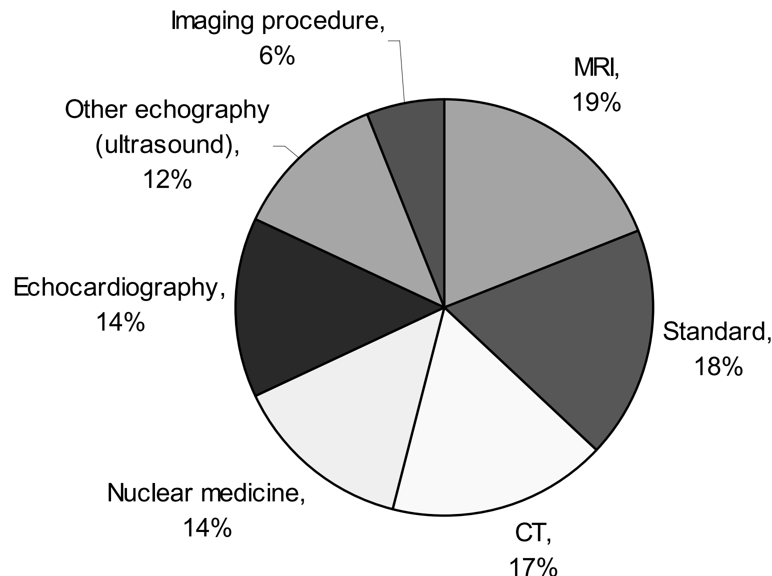
	2000	2001	2002	2003	2004	2005	2006	2007
Medicare payments (billions of dollars)	$1.4	$1.6	$1.9	$2.2	$2.5	$2.7	$2.9	$2.9
Number of centers	3,028	3,371	3,597	3,887	4,136	4,506	4,707	4,964
New centers	295	446	309	365	315	467	261	267
Exiting centers	53	103	83	75	66	97	60	10
Net percent growth in number of centers from previous year	8.7%	11.3%	6.7%	8.1%	6.4%	8.9%	4.5%	5.5%
Percent of all centers that are:								
For profit	94	94	95	95	96	96	96	96
Nonprofit	6	5	5	5	4	4	4	4
Urban	88	88	87	87	87	87	88	88
Rural	12	12	13	13	13	13	12	12

Note: ASC (ambulatory surgical center). Medicare payments include program spending and beneficiary cost sharing for ASC facility services. Payments for 2007 are preliminary and subject to change. Totals may not sum to 100 percent due to rounding.

Source: MedPAC analysis of provider of services files from CMS, 2000–2007. Payment data are from CMS, Office of the Actuary.

- Ambulatory surgical centers (ASCs) are entities that furnish outpatient surgical services not requiring an overnight stay. To receive payments from Medicare, ASCs must meet Medicare's conditions of coverage, which specify minimum facility standards.
- Most Medicare-certified ASCs are for-profit facilities and are located in urban areas.
- Medicare uses a new payment system for ASC services that is based on the hospital outpatient prospective payment system (PPS). ASC rates are less than hospital outpatient rates because of a budget neutrality requirement. In contrast to the old ASC system, which had only nine procedure groups, the new system has several hundred procedure groups. The new system will be phased in over four years.
- Total Medicare payments for ASC services increased by 11.4 percent per year, on average, from 2000 through 2007. Payments per beneficiary grew by 10.2 percent per year during this period. The growth in spending was slowed in 2006 and 2007 by large increases in the number of Medicare Advantage enrollees, who are not included in these aggregate totals. Spending growth was also slowed in 2007 by a provision in the Deficit Reduction Act of 2005, which capped the ASC rate for each service at the outpatient PPS rate.
- The number of Medicare-certified ASCs grew at an average annual rate of 7.3 percent from 2000 through 2007. Each year from 2000 through 2007, an average of 341 new Medicare-certified facilities entered the market, while an average of 68 closed or merged with other facilities.

Chart 8-14. Medicare spending for imaging services, by type of service, 2006

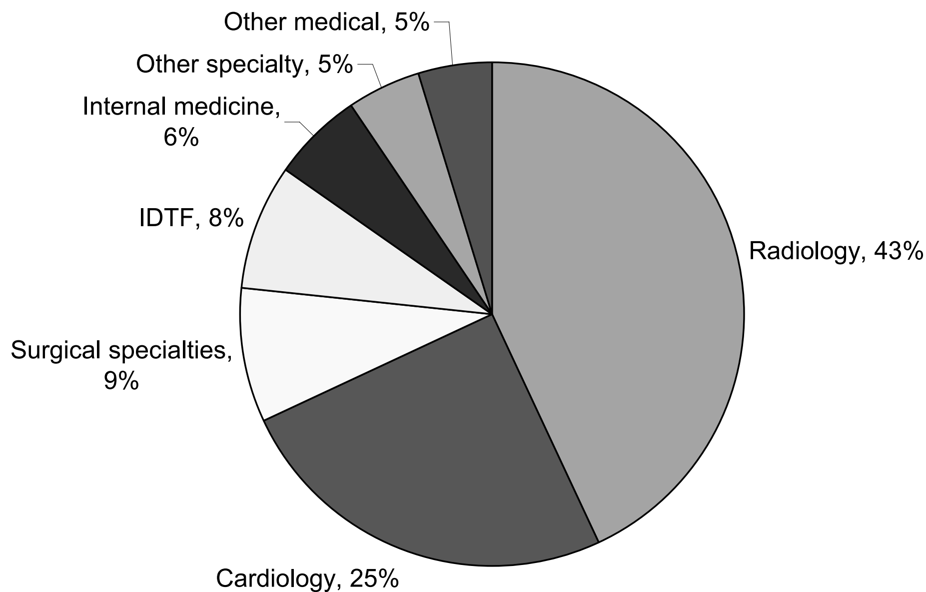


Note: CT (computed tomography), MRI (magnetic resonance imaging). Imaging procedure includes cardiac catheterization and angiography. Medicare payments include program spending and beneficiary cost sharing for physician fee schedule imaging services. Totals may not sum to 100 percent due to rounding.

Source: MedPAC analysis of 100 percent physician/supplier procedure summary file from CMS, 2006.

- More than one-third of Medicare spending for imaging under the physician fee schedule is for computed tomography (CT) and magnetic resonance imaging (MRI) studies. Ultrasound services (echocardiography and other echography) account for one-quarter of imaging spending.
- Medicare spending for imaging services under the physician fee schedule nearly doubled between 2000 and 2006, from $6.4 billion to $12.3 billion. Spending for MRI, echocardiography, CT, and nuclear medicine has grown faster than for other imaging services. Thus, these categories account for a larger share of total imaging spending in 2006 than they did in 2000.

Chart 8-15. Radiologists received about 40 percent of Medicare payments for imaging services, 2006



Note: IDTF (independent diagnostic testing facility). Medicare payments include program spending and beneficiary cost sharing for physician fee schedule imaging services. Total fee schedule imaging spending was $12.3 billion in 2006. IDTFs are independent of a hospital and physician's office and provide only outpatient diagnostic services. Other medical includes family practice, general practice, neurology, rheumatology, pulmonary disease, hematology/oncology, and endocrinology. Other specialty includes otolaryngology, pain management, osteopathic, physical medicine, nephrology, podiatry, cardiac surgery, oncology, and portable X-ray suppliers.

Source: MedPAC analysis of 100 percent physician/supplier procedure summary file from CMS, 2006.

- Imaging services paid under the physician fee schedule involve two parts: the technical component, which covers the cost of the equipment, supplies, and nonphysician staff, and the professional component, which covers the physician's work in interpreting the study and writing a report. A physician who both performs and interprets the study submits a global bill, which includes the technical and professional components.

- Although radiologists received three-quarters of Medicare payments for professional component services in 2006, they accounted for much smaller shares of spending for global bills (32 percent) and technical component services (12 percent).

- Between 2002 and 2006, radiologists' share of total imaging payments declined by 2.2 percent per year while the shares for other providers increased. For example, other medical's share of payments grew by 3.2 percent per year, independent diagnostic testing facilities by 3.0 percent per year, and cardiology by 2.4 percent per year.

Web links. Ambulatory care

Physicians

- For more information on Medicare's payment system for physician services, see MedPAC's Payment Basics series.

  http://medpac.gov/documents/MedPAC_Payment_Basics_07_Physician.pdf

- Chapter 2B of the MedPAC March 2008 Report to the Congress and Appendix A of the June 2008 Report to the Congress provide additional information on physician services.

  http://www.medpac.gov/chapters/Mar08_Ch02b.pdf
  http://www.medpac.gov/chapters/Jun08_AppA.pdf

- MedPAC's congressionally mandated report, *Assessing Alternatives to the Sustainable Growth Rate (SGR) System*, examines the SGR and analyzes alternative mechanisms for controlling physician expenditures under Medicare.

  http://www.medpac.gov/documents/Mar07_SGR_mandated_report.pdf

- Congressional testimony by the Chairman and Executive Director of MedPAC discusses payment for physician services in the Medicare program. This includes:

  Payments to selected fee-for-service providers (May 15, 2007)
  http://www.medpac.gov/documents/051507_WandM_Testimony_MedPAC_FFS.pdf

  Options to improve Medicare's payments to physicians (May 10, 2007)
  http://www.medpac.gov/documents/051007_Testimony_MedPAC_physician_payment.pdf

  Assessing alternatives to the Sustainable Growth Rate System (March 6, 2007)
  http://www.medpac.gov/documents/030607_W_M_testimony_SGR.pdf

  Assessing alternatives to the Sustainable Growth Rate System (March 6, 2007)
  http://www.medpac.gov/documents/030607_E_C_testimony_SGR.pdf

  Assessing alternatives to the Sustainable Growth Rate System (March 1, 2007)
  http://www.medpac.gov/documents/030107_Finance_testimony_SGR.pdf

  MedPAC recommendations on imaging services (July 18, 2006)
  http://medpac.gov/publications/congressional_testimony/071806_Testimony_imaging.pdf

  Medicare payment to physicians (July 25, 2006)
  http://www.medpac.gov/publications/congressional_testimony/072506_Testimony_physician.pdf

- The 2008 Annual Report of the Boards of Trustees of the Hospital Insurance and Supplementary Medical Insurance Trust Funds provides details on historical and projected spending on physician services.

  http://www.cms.hhs.gov/ReportsTrustFunds/downloads/tr2008.pdf

Hospital outpatient services

- For more information on Medicare's payment system for hospital outpatient services, see MedPAC's Payment Basics series.

  http://www.medpac.gov/documents/MEDPAC_Payment_Basics_07_opd.pdf

- Section 2A of the MedPAC 2008 Report to the Congress provides information on the status of hospital outpatient departments including supply, volume, profitability, and cost growth.

  http://www.medpac.gov/chapters/Mar08_Ch02a.pdf

- Section 2A of the MedPAC 2006 Report to the Congress provides information on the current status of "hold-harmless" payments and other special payments for rural hospitals.

  http://www.medpac.gov/publications/congressional_reports/Mar06_Ch02a.pdf

- Chapter 3A of the MedPAC March 2004 Report to the Congress provides additional information on hospital outpatient services, including outlier and transitional corridor payments.

  http://www.medpac.gov/publications/congressional_reports/Mar04_Ch3A.pdf

- More information on new technology and pass-through payments can be found in Chapter 4 of the MedPAC March 2003 Report to the Congress.

  http://www.medpac.gov/publications/congressional_reports/Mar03_Ch4.pdf

Ambulatory surgical centers

- For more information on Medicare's payment system for ambulatory surgical centers, see MedPAC's Payment Basics series.

  http://medpac.gov/documents/MedPAC_Payment_Basics_07_ASC.pdf

- Chapter 3F of the MedPAC March 2004 Report to the Congress provides additional information on ambulatory surgical centers.

  http://www.medpac.gov/publications/congressional_reports/Mar04_Ch3F.pdf