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MEDICARE

Impact of Changing Transportation Policy for Portable Equipment Is Uncertain

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May 18, 1998

The Honorable Bill Archer
Chairman, Ways and Means Committee
House of Representatives

The Honorable Thomas J. Bliley, Jr.
Chairman, Committee on Commerce
House of Representatives

The Honorable Bill Thomas
Chairman, Subcommittee on Health
Committee on Ways and Means
House of Representatives

The Honorable Michael Bilirakis
Chairman, Subcommittee on Health
and Environment
Committee on Commerce
House of Representatives

The Honorable James C. Greenwood
House of Representatives

The Health Care Financing Administration (HCFA)—the agency that administers the Medicare program—reduced payments to certain providers who perform electrocardiogram (EKG) and ultrasound examinations in nursing homes and beneficiaries' residences. In the past, Medicare had permitted these providers of these portable diagnostic tests to receive, in addition to the fee for performing the test, a separate payment for transporting the necessary equipment. However, HCFA eliminated separate transportation payments for ultrasound services effective January 1, 1996. HCFA eliminated separate transportation payments for EKG services effective January 1, 1997, but these payments were temporarily restored by the Balanced Budget Act of 1997 (BBA).

Some claim that eliminating separate transportation payments could ultimately increase Medicare outlays and adversely affect beneficiaries. They argue that providers will be less willing to provide EKG and ultrasound services without a separate transportation payment. As a consequence, Medicare could incur ambulance charges for homebound

beneficiaries or those in nursing facilities to travel to hospitals for EKG and ultrasound diagnostic tests.

Concerned over the possible adverse effect of the revised payment policies, you asked us to study how HCFA's change would affect Medicare beneficiaries and program costs. To address your concerns, we identified and analyzed (1) the Medicare recipients, places of service, and providers who might be affected most; (2) the number of services that would be affected by the changed policy; and (3) the effect on Medicare's program costs.

We analyzed a national sample of Medicare claims data for 1995—the last year in which carriers could pay separate transportation fees for both ultrasound and EKG equipment. Because relatively few of these diagnostic tests were performed in beneficiaries' residences, we focused our attention on tests conducted in nursing homes. With help from appropriate medical personnel, we reviewed medical records of nursing home residents in two states who had received either ultrasound or EKG services in the home during 1995. In addition, we discussed HCFA's policy with HCFA officials and industry representatives and sought the opinions of several medical associations and health care associations. We performed our work between April 1997 and February 1998 in accordance with generally accepted government auditing standards except that we did not verify HCFA's data. We note, however, that this database, consisting of all Medicare Part B claims for a 5-percent sample of beneficiaries, is often used by researchers investigating important issues in health economics and policy. (See app. I for the scope and methodology.)

Results in Brief

Only a fraction of the EKG and ultrasound tests paid for by Medicare are performed outside of physicians' offices or hospital settings and, thus, are potentially affected by the payment policy changes. In 1995, Medicare paid approximately $597 million for 14 million EKGs and about $976 million for 5 million ultrasound tests in various settings. Only 290,000 of the EKGs and only 37,000 of the ultrasound tests were done in locations such as nursing homes or beneficiaries' residences where the provider needed to transport the diagnostic equipment. Nearly 90 percent of the services that required transporting equipment were provided to residents of nursing homes. They were usually provided by portable x-ray and ultrasound providers. Some states appear to have a higher concentration of these services, with a small number of providers accounting for a large portion of each state's total portable EKG and ultrasound services.

Many EKGs and ultrasound services provided in nursing homes would be unaffected if transportation payments were eliminated. Given the experience of 1995, about 56 percent (142,400) of the EKGs and 89 percent (26,900) of the ultrasound services provided in nursing homes would be unaffected by transportation payment changes and presumably would continue to be provided in those settings. One reason some tests would be unaffected is that, beginning in July 1998, nursing homes will receive an inclusive per diem payment for all services provided to beneficiaries receiving Medicare-covered skilled nursing care. A decision to eliminate or retain separate transportation payments for other beneficiaries will not affect the per diem payment. Another reason is that many nursing home EKGs and most ultrasound services in 1995 were performed by providers who did not receive a transportation payment.

The effect of eliminating transportation payments on the remaining 44 percent of the EKG and 11 percent of the ultrasound services is unknown because it depends on how providers respond. If mobile providers are less willing to transport equipment, then services for homebound beneficiaries and nursing home residents may decline. Alternatively, providers may continue to supply services or, especially in the case of EKGs, nursing homes may decide to purchase the equipment and provide the tests themselves.

Because relatively few services would be affected, eliminating transportation payments would likely have a nominal effect on Medicare spending. Medicare could save $11 million if mobile providers continue to supply services. However, if mobile providers stopped bringing portable EKG equipment to beneficiaries, then some people would travel in Medicare-paid ambulances to obtain these tests. If that happened, the annual net cost to Medicare could be as much as $9.7 million. Eliminating transportation payments for ultrasound services would have a smaller effect. We estimate the effect on Medicare spending might range from $400,000 in savings to $125,000 in increased costs.

Background

Generally, HCFA considers transportation costs to be part of physicians' practice expense for a service under Medicare's physician fee schedule. For example, physicians do not receive separate transportation payments when they visit Medicare beneficiaries in nursing homes. However, this policy is not followed when it comes to the transportation of equipment used to do diagnostic tests. HCFA established specific guidance for carriers to follow regarding portable x-ray and EKG services. Because HCFA did not

issue specific instructions for other diagnostic tests, such as ultrasound, each Medicare carrier developed its own policies.

Section 1861(s)(3) of the Social Security Act provides the basis for the coverage of diagnostic x-rays furnished in a Medicare beneficiary's residence. HCFA believes that because of the increased costs associated with transporting x-ray equipment to the beneficiary, the Congress intended for HCFA to pay an additional amount for the transportation service furnished by an approved portable x-ray supplier. Thus, HCFA has established specific procedure codes to pay for the transportation of x-ray equipment.

HCFA added EKG services allowed in homes to the established list of approved services that suppliers may provide and established a code to pay for the transportation of EKG equipment. Many Medicare carriers limited payment of transportation costs for EKG services to portable x-ray suppliers. However, others had allowed it for other types of providers such as independent physiological laboratories (IPL).

HCFA never established a national policy for transportation costs related to ultrasound services. Each carrier developed its own policy. Medical directors for each of the carriers decided whether to reimburse for transportation costs separately. In 15 states, carriers had a policy to reimburse separately for transportation costs associated with ultrasound services.

Beginning January 1, 1996, carriers could allow transportation payments for only the following services: (1) x-ray and standard EKG services furnished by an approved portable x-ray supplier and (2) standard EKG services furnished by an IPL under special conditions. For all other types of diagnostic tests payable under the physician fee schedule, travel expenses were considered "bundled" into the procedure payment. For example, carriers could no longer make separate transportation payments associated with ultrasound services.

After further review, HCFA again revised its policy. HCFA concluded that the statute authorized carriers to make separate transportation payments only for portable x-ray services. Therefore, HCFA published a final regulation providing that effective January 1, 1997, carriers would no longer make separate transportation payments associated with EKG services.

The enactment of the Balanced Budget Act in August 1997 caused additional changes in Medicare's transportation payment policy. First, BBA temporarily restored separate payments for transporting EKG equipment but not ultrasound equipment during 1998. The law requires the Secretary of Health and Human Services to make a recommendation by July 1, 1998, to the Committees on Commerce and Ways and Means of the House of Representatives and the Committee on Finance of the Senate on whether there should be a separate Medicare transportation fee for portable EKGs starting in 1999.

Second, BBA phases in a prospective payment system for skilled nursing care that will pay an all-inclusive per diem rate for covered services. Beneficiaries needing skilled care after being discharged from the hospital are covered under Part A for 100 days of care during a benefit period. Part A coverage includes room and board, skilled nursing and rehabilitative services, and other services and supplies. Thus, the per diem rate paid to nursing facilities would include all services during the period the beneficiary is receiving posthospital extended care.[1] For example, services such as EKGs and ultrasound will no longer be paid for separately but will be included in the per diem rate. The prospective payment provision begins July 1, 1998.

Third, BBA establishes an ambulance service fee schedule beginning in 2000. This provision is designed to help contain Medicare spending on ambulance service.

Nearly 90 Percent of Portable EKGs and Ultrasound Tests Are Done in Nursing Homes

Medicare paid for more than 14 million EKG and 5 million ultrasound services in 1995 at a cost to the Medicare program of about $597 and $976 million, respectively. Most EKG and ultrasound services were performed in physicians' offices or hospitals. In 1995, about 2 percent of the EKG and less than 1 percent of the ultrasound services were provided in beneficiaries' homes or nursing homes, costing the Medicare program about $12 million for the EKGs and $8 million for the ultrasound services. Of these services, about 88 percent of the EKG and 82 percent of the ultrasound services were done in a nursing home. These services were usually provided by portable x-ray suppliers and IPLs. Table 1 compares these services in these settings.

[1]The prospective rates will not include transportation payments for EKG equipment during 1998, so separate payments will be made during this year.

Table 1: EKG and Ultrasound Services in Residences, 1995

Setting	EKG	Ultrasound
Nursing facility	255,180	30,120
Home	34,500	6,720
Total	**289,680**	**36,840**

Because HCFA regulations allowed EKG service transportation payments to be paid only to portable x-ray providers and certain IPLs for EKG services done in a beneficiary's residence, it is not surprising that these providers accounted for 83 percent of all Medicare EKG services performed in nursing homes. Likewise, these two types of providers accounted for a high portion of the Medicare ultrasound services provided in nursing homes. General practitioners, cardiologists, and internists also provided EKG and ultrasound services.

In 1995, 1,317 providers were doing EKGs and 337 were doing ultrasound services in nursing homes.[2] Of the total EKG providers, 676 were portable x-ray suppliers and 75 were IPLs. Of the total ultrasound providers, 51 were portable x-ray suppliers and 83 were IPLs, and combined they accounted for more than half of the ultrasound services done in nursing homes.

Nursing Home EKGs and Ultrasound Were Concentrated in Certain States

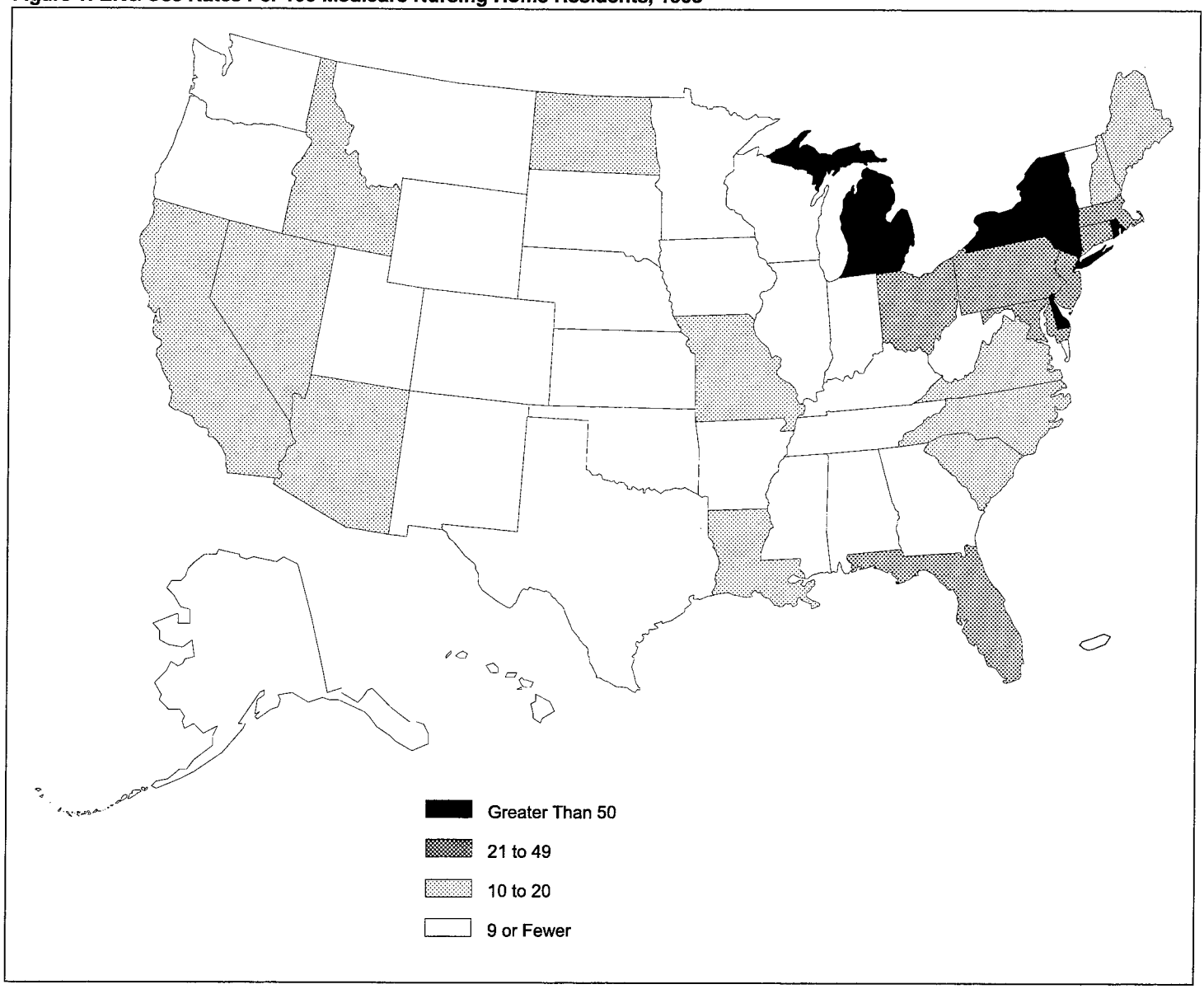
About one-fifth of the states accounted for a disproportionately high concentration of EKG and ultrasound services in 1995, compared with these states' nursing home populations.[3] In addition, it appears that these services were generally provided by a few large providers. Thus, this change in transportation policy will have a larger effect on Medicare spending in some geographic areas.

Eleven states accounted for nearly three-fourths of the 255,000 EKGs done in nursing homes. This appears to be disproportionately high when compared with the nursing home population in the 11 states. Figure 1 shows the use rates in each state per 100 Medicare nursing home residents.

[2]These numbers were based on a national database consisting of all Medicare Part B claims from a 5-percent sample of beneficiaries that we believe identified most of the providers in 1995.

[3]Connecticut, Delaware, Florida, Maryland, Massachusetts, Michigan, New Jersey, New York, Ohio, Pennsylvania, Rhode Island.

Figure 1: EKG Use Rates Per 100 Medicare Nursing Home Residents, 1995



Furthermore, a handful of providers in each of these states accounted for most of the services. For example, in New York 7 percent of the providers accounted for 77 percent of the services. (See table 2.)

Table 2: Providers Performing Portable EKG Services in 11 States, 1995

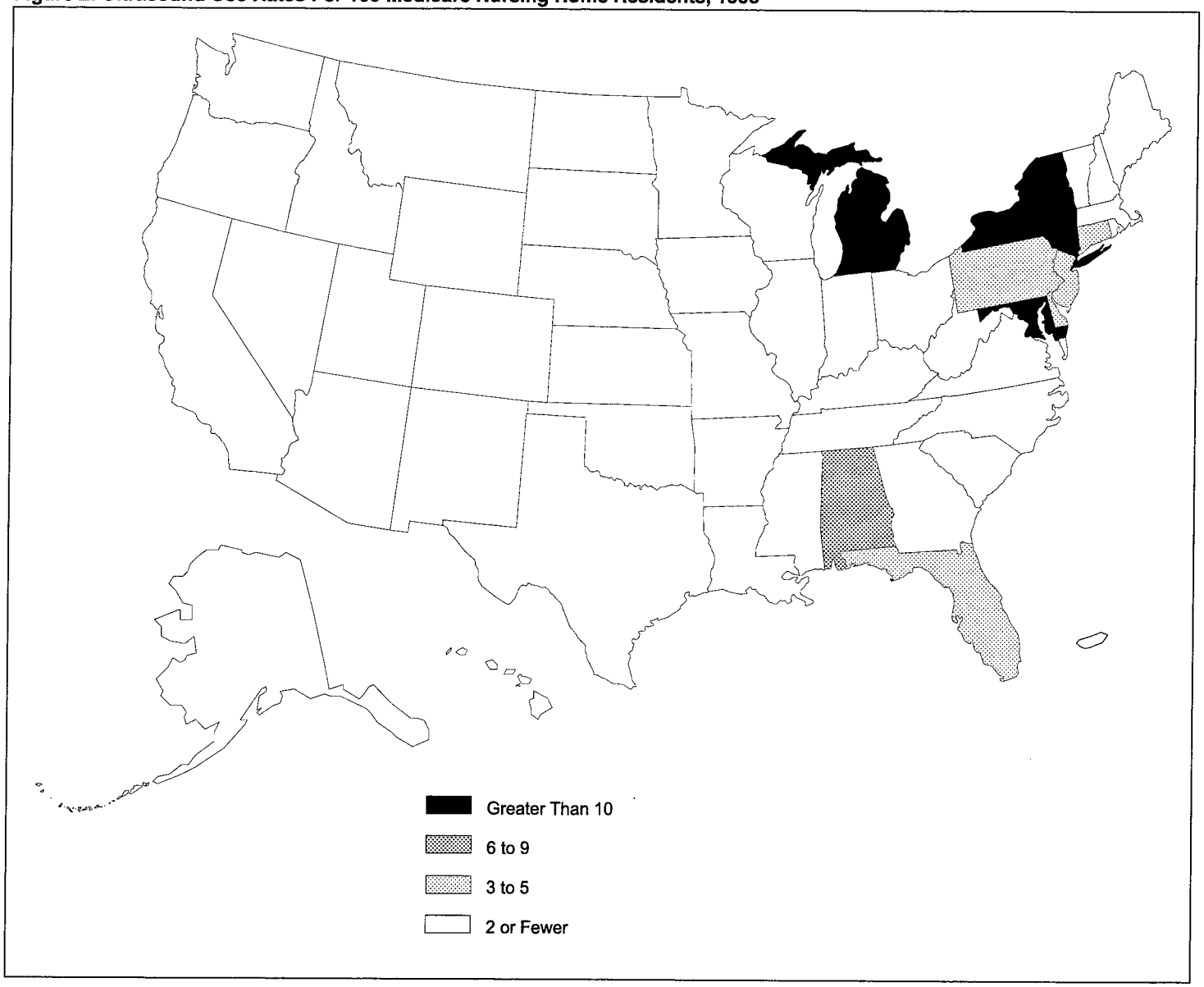
State	Total number of providers	High-volume provider[a]	
		Number	Percentage of total service supplied
Connecticut	54	6	74%
Delaware	11	2	70
Florida	88	6	65
Maryland	35	2	50
Massachusetts	54	5	76
Michigan	46	8	88
New Jersey	56	11	77
New York	204	14	77
Ohio	60	6	60
Pennsylvania	75	7	68
Rhode Island	14	1	64

[a]High-volume providers provided 500 or more services in the state in 1995.

Similarly, the data show that 10 states accounted for more than 84 percent of the ultrasound services done in nursing homes in 1995.[4] The use rate in these 10 states appears to be somewhat higher than in the 40 other states. Figure 2 shows the ultrasound use rates in each state.

[4]Alabama, California, Connecticut, Florida, Maryland, Michigan, New Jersey, New York, Pennsylvania, and Texas.

Figure 2: Ultrasound Use Rates Per 100 Medicare Nursing Home Residents, 1995



Less than half of the portable x-ray suppliers and IPLs did most of the ultrasound services for which separate transportation payments were made, and only a handful of them did more than half of these services. Data show that 54 portable x-ray suppliers and IPLs did 89 percent of these services. Further, 11 of these 54 providers accounted for 52 percent of the

transportation claims. Similar to what we found in the EKG data, there were a few high-volume providers in the 10 states, as shown in table 3.

Table 3: Providers Performing Portable Ultrasound Services in 10 States, 1995

		High-volume provider[a]	
State	Total number of providers	Number	Percentage of total service supplied
Alabama	5	1	93%
California	19	4	73
Connecticut	13	3	53
Florida	25	2	28
Maryland	19	3	71
Michigan	16	3	75
New Jersey	24	1	35
New York	65	2	24
Pennsylvania	30	2	35
Texas	22	4	60

[a]High-volume providers accounted for more than 10 percent of the services in the state in 1995.

EKG and Ultrasound Services Are Likely to Be Available in Nursing Homes After Revised Payment Policy

About 19 percent of the EKGs and 21 percent of the ultrasound tests done in nursing homes in 1995 would be unaffected by any change in the transportation payment policy because BBA eliminates separate payments for services provided to beneficiaries in skilled facilities while their stay is covered under posthospital extended care. An additional 37 percent of the portable EKGs and 68 percent of the ultrasound tests were done without the providers' receiving additional payments for transporting the equipment. Consequently, 56 percent of the EKG services and 89 percent of the ultrasound tests provided to beneficiaries in their place of residence would be unaffected by the elimination of separate transportation payments.

There is some uncertainty, however, as to whether (and to what extent) providers will cut back on services for which they previously received a transportation payment. Nonetheless, it is reasonable to assume that at least some of these services would also continue under a revised payment policy. If providers reduced services in nursing homes, some residents would be inconvenienced by having to travel to obtain these tests. In some instances, the nursing home may need to provide transportation or staff to

accompany a resident to a test site. Consequently, nursing homes could be affected as well.

EKG and Ultrasound Services for Some Nursing Home Residents Are Covered Under Prospective Payment

In the future, all services provided to Medicare beneficiaries in skilled facilities who are under posthospital extended care will be included under a per diem prospective payment rate. Nursing facilities will receive a per diem rate for routine services such as room and board and all other services such as EKGs and ultrasound. Based on the 1995 data, 19 percent (48,000) of the EKG services and 21 percent (6,520) of the ultrasound services will be incorporated under the prospective rates.

Nearly Half of All Nursing Home EKGs Are Done Without Separate Transportation Payments

In 1995, only portable x-ray suppliers and certain IPLs received separate transportation payments. Therefore, any EKG services done in nursing homes by other medical providers such as general practitioners, internists, and cardiologists did not include separate transportation payments. Data for 1995 show that 55,580 of the EKG services done in nursing homes did not include a separate transportation payment. (See table 4.)

Table 4: EKG and Ultrasound Services Performed in Nursing Facilities in 1995

	EKG	Ultrasound
Total services	255,180	30,120
Less services		
Affected by BBA	48,000	6,520
Without transportation fee	55,580	20,200
Services with x-ray	38,820	180
Services unaffected	**142,400**	**26,900**
Percentage	56%	89%

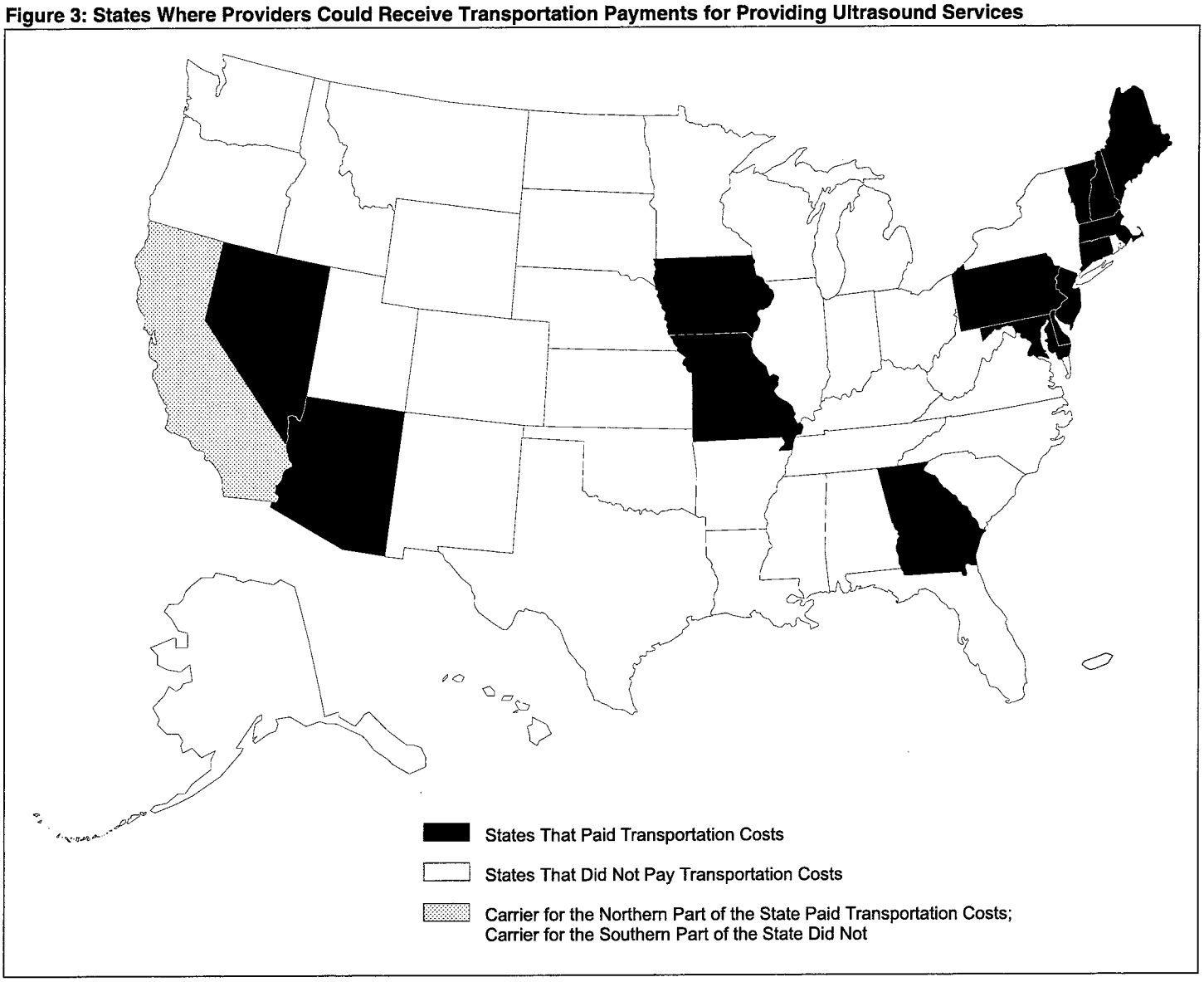
When an EKG or ultrasound service is done in conjunction with an x-ray, the provider receives a transportation fee for the x-ray service but not the EKG or ultrasound. The 1995 data covering EKG services with separate transportation payments show that 38,820 of the beneficiaries who received an EKG service also had an x-ray service done during the same visit. Thus, any provider doing an EKG and an x-ray service would continue to receive a separate transportation payment for the x-ray service.

Most Nursing Home Ultrasound Services Are Done Without Separate Transportation Payments

Before HCFA issued regulations in December 1995, Medicare providers in less than a third of the states were paid for transporting ultrasound equipment to beneficiaries' residences. Each carrier had its own policy regarding reimbursement for ultrasound equipment transportation costs. Carrier representatives responsible for Medicare Part B program payments in only 14 states and part of another told us that they had a policy to make transportation payments when billed for ultrasound services.[5] See figure 3.

[5]The two carriers responsible for California had different policies concerning transportation fees relating to ultrasound. The carrier responsible for claims in the northern part of the state reimbursed transportation costs whereas the carrier responsible for claims in the southern part of the state did not.

Figure 3: States Where Providers Could Receive Transportation Payments for Providing Ultrasound Services



Because carriers responsible for fewer than one-third of the states allowed separate transportation payments, most ultrasound services performed in nursing homes were done without such payment. Only 3,220 (15 percent) of the 23,600 ultrasound services done in nursing homes in 1995 had claims for separate transportation payments. The remainder,

approximately 20,380, were done without a separate transportation payment. (See table 4.)

Even in states where carriers had a policy to pay separate transportation payments, there were many instances in which providers performed ultrasound services in nursing homes but did not receive a separate transportation payment. For example, in Maryland and Pennsylvania, where carriers had policies to make separate transportation payments, 79 and 55 percent, respectively, of the ultrasound services done in nursing homes by providers did not involve separate transportation payments.

The average frequency of ultrasound tests per nursing home resident varied among states but did not vary systematically with carriers' transportation payment policies. That is, there is no indication from the 1995 data that nursing home residents systematically received fewer services in states that did not make separate transportation payments compared with residents in states that did pay. For example, Michigan and New York—states where separate transportation payments were generally not made—had high ultrasound use rates, while Massachusetts—where separate transportation payments were made—had a low rate.

Potential Effect on Medicare Beneficiaries Is Not Clear

Advocacy groups gave contradictory opinions as to the possible effects HCFA's changed policy would have on Medicare beneficiaries. Generally, officials representing medical groups believed that EKG and ultrasound services would continue to be available and thus did not see an adverse effect on the availability of care for patients. In contrast, representatives from nursing homes and EKG provider associations expressed concern about potential decreases in quality of care, especially for frail elderly beneficiaries who would be most affected by being transported away from their homes. In addition, officials at several nursing homes we visited said that sending beneficiaries out also imposes additional costs and burdens on the nursing home because often these beneficiaries have to be accompanied by a nursing home representative.

Potential Program Savings Depends on Provider Response to Revised Transportation Payment Policy

We cannot predict whether the revised payment policy will decrease or increase Medicare spending because we do not know the extent to which providers will continue to supply portable EKG and ultrasound services without separate transportation payments. Because of these uncertainties, we developed a range estimate of potential savings and costs associated with the revised payment policy.

Medicare Savings Are Possible If EKGs and Ultrasound Tests Remain Available in Nursing Homes

In 1995, if the prospective payment system for skilled nursing care and the policy of not making transportation payments had been in effect, Medicare outlays would have been lower by as much as $11 million on EKGs and $400,600 on ultrasound services. However, these savings would have materialized only to the extent that homebound beneficiaries and nursing home residents did not travel outside in Medicare-paid ambulances to receive these tests. We cannot predict the likelihood that savings will be realized because they depend upon the future actions of portable equipment providers and nursing home operators.

Providers of portable equipment may continue to provide EKG and ultrasound services even if they no longer receive the separate transportation payments. Many mobile providers have established private business relationships with the nursing homes they serve and may be eager to maintain those relationships. In addition, many also provide other services to nursing homes, such as x-ray services. Therefore, they would be likely to continue EKG services to some degree.

Prospective payment may change the way nursing facilities provide services. Some nursing homes may purchase the equipment to provide diagnostic tests in house. Representatives from two of the seven nursing homes we visited told us that they were considering purchasing EKG equipment and having nursing home staff perform the tests.[6] The representatives noted that this would be feasible because EKG equipment is relatively inexpensive and staff need only limited training to perform the tests (no certification is needed). They also noted that residents needing EKGs would receive quicker service if the equipment were always on the premises.

[6]We did not explicitly ask nursing home representatives whether they were considering this course of action. Consequently, it is possible that some of the other nursing homes were also considering purchasing and using EKG equipment.

Because nursing homes may have additional transportation or staff costs for each test, the revised payment policy may produce Medicare savings by reducing the use of EKG and ultrasound services. During our review of case files at selected nursing homes, we observed a number of instances in which beneficiaries entering the nursing home were receiving EKG tests, although there were no indications that these beneficiaries were experiencing any problems to warrant such tests. In many of these situations, nursing home officials said that the tests provided baseline information. To the extent that eliminating the transportation payment would reduce inappropriate screening tests billed to Medicare, it would produce savings.

Medicare Costs Could Increase If Many Beneficiaries Travel by Ambulance to Obtain Tests

Eliminating separate transportation payments could increase Medicare spending if beneficiaries travel to hospitals or physicians' offices to be tested. Some very sick or frail beneficiaries would need to travel by ambulance. We found that the costs for the service itself are about the same whether the service is delivered in a hospital, a physician's office, or a nursing home. However, the cost of transporting a beneficiary by ambulance is substantially greater than the amount paid to mobile providers for transporting equipment to a beneficiary's residence.

We estimate that the potential annual net costs to Medicare from eliminating transportation payments could be as much as $9.7 million for EKGs and $125,000 for ultrasound tests. These estimates, based on 1995 data, represent an upper limit that would be reached only if equipment providers stopped providing all services for which they previously received a transportation payment and the beneficiaries were transported by ambulance to receive the services. Our net cost estimates are based on (1) the number of beneficiaries who would be likely to need transporting by ambulance to receive EKG and ultrasound services, (2) the cost of ambulance transportation, and (3) the costs of EKGs and ultrasound tests in other settings.

Number of Beneficiaries Who Would Likely Need Ambulance Transportation

We estimate that about half of the beneficiaries who received an EKG and more than one-third of the beneficiaries who received an ultrasound service in 1995 would likely have been transported by ambulance had the equipment not been brought to them. Our estimates are based on our review of beneficiary case files from several nursing homes in two states. (See appendix I for more detail.)

Cost of Ambulance Transportation

The transportation payments by Medicare for ambulance services are significantly greater than the transportation payments made to providers of portable EKG and ultrasound equipment.[7] In 1995, the average ambulance transportation payment for beneficiaries in skilled nursing facilities who were transported for an EKG test ranged from $164 (for an average trip in North Carolina) to $471 (for an average trip in Connecticut). For the same period, the average payment made for transporting EKG equipment to a nursing home ranged from about $26 (in Illinois) to $145 (in Hawaii, Maine, Massachusetts, New Hampshire, and Rhode Island).

Cost of Diagnostic Tests in Other Settings

The cost for EKG or ultrasound services is about the same in every setting. Anywhere other than a hospital outpatient setting, the Medicare payment for the service is determined by the physician fee schedule. In a hospital outpatient setting, Medicare payments for services such as EKGs and ultrasound tests are limited to the lesser of reasonable costs, customary charges, or a "blended amount" that relates a percentage of the hospital's costs to a percentage of the prevailing charges that would apply if the services had been performed in a physician's office.[8] Our analysis of 1995 hospital cost reports does not suggest that Medicare would pay more for the services if they were performed at a hospital.

Conclusions

While millions of EKG and ultrasound tests are provided yearly to Medicare beneficiaries, only a small percentage of these tests are performed in a beneficiary's home or nursing home. Many of the EKGs and most of the ultrasound tests performed in those settings would be unaffected by the elimination of separate transportation payments.

We cannot predict how providers of portable EKG and ultrasound equipment will react over the long term to the elimination of transportation payments or what actions nursing homes might take to provide services if they were not delivered. Also, we cannot predict what actions skilled facilities may take as a result of the prospective payment system that will be implemented. Consequently, our estimate of the effect of a revised payment policy ranges from a savings of $11 million to a cost

[7]The growth in ambulance payments may be better contained in the future because BBA requires HCFA to establish a fee schedule for ambulance charges beginning in 2000.

[8]The blended amount is based on 50 percent of the hospital's cost or charges and 50 percent based on 42 percent of the global prevailing charges that would be paid for the same procedures if performed in a physician's office.

of $9.7 million for EKG tests and a savings of $400,000 to a cost of $125,000 for ultrasound tests.

Because providers' reactions are uncertain, HCFA would have to eliminate transportation payments to reliably gauge the revised policy's effect on Medicare spending. By carefully monitoring the revised policy over a sufficient period of time, HCFA could determine whether the revised payment policy caused a net decrease in Medicare spending or a net increase. In the absence of such hard data, however, we cannot recommend a specific course of action regarding the retention or elimination of separate Medicare transportation payments for portable EKG and ultrasound tests.

Agency Comments and Our Evaluation

HCFA officials stated that our methodology was appropriate and that they generally agreed with the results of our review. Furthermore, they agreed that precisely estimating the potential cost of the revised payment policy is difficult. However, HCFA officials believe that the upper limit of our potential Medicare spending estimate is based on very conservative assumptions and that this amount of additional Medicare spending is unlikely to occur if separate transportation payments are eliminated. We agree that our approach was conservative so as not to understate the potential for additional Medicare spending. However, as we state in the report, if providers continue to supply these services for business reasons, then Medicare might save money or incur additional costs below our estimated upper limit because fewer beneficiaries would need transporting by ambulance for the services. This would also be true, especially in the case of EKGs, if nursing homes purchase the necessary equipment and keep it on site.

HCFA officials were also concerned over what appears to be a disproportionate amount of EKG and ultrasound services by a few providers in selected states. HCFA officials thought this pattern may indicate potential abuse. We did not attempt to determine appropriate use rates for these services and thus cannot conclude whether the rates are too high or too low in some areas. Our purpose in showing the concentration of EKG and ultrasound services was to provide some perspective on the beneficiaries likely to be most affected by HCFA's changed payment policy.

We incorporated other HCFA comments in the final report where appropriate.

As agreed with your office, unless you publicly announce the contents earlier, we plan no further distribution of this report until 30 days from the date of this letter. We will then send copies to the Secretary of the Department of Health and Human Services, the Administrator of HCFA, interested congressional committees, and others who are interested. We will also make copies available to others on request.

Please call James Cosgrove, Assistant Director, at (202) 512-7029 if you or your staffs have any questions about this report. Other major contributors include Cam Zola and Bob DeRoy.

William J. Scanlon
Director, Health Financing
and Systems Issues

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Abbreviations

BBA	Balanced Budget Act of 1997
EKG	electrocardiogram
HCFA	Health Care Financing Administration
IPL	independent physiological laboratory

Scope and Methodology

To obtain information on electrocardiogram (EKG) and ultrasound tests done in 1995, we extracted pertinent use data from a national database consisting of all Medicare Part B claims from a 5-percent sample of beneficiaries.[9] We used valid 1995 EKG and ultrasound procedure codes for the diagnostic procedure itself. We eliminated all codes that represented only a physician's interpretation or report and codes for procedures that were delivered in settings other than nursing homes. We used 1995 data because it was the last year in which both EKG and ultrasound transportation costs could have been reimbursed under Medicare. In addition, we obtained data on outpatient costs for radiological and other diagnostic tests for all hospitals reporting such data to the Health Care Financing Administration (HCFA) in 1995. Because paying transportation costs relating to ultrasound services was a "local" decision, we contacted all the Medicare Part B carriers to determine the reimbursement practices in effect in every state in 1995.

We visited 12 judgmentally chosen nursing homes in Florida and Pennsylvania and randomly selected 176 cases of beneficiaries who had an EKG or ultrasound test done in the home during 1995. We discussed the reasons for the test and the general condition of the beneficiary at the time of the test with an appropriate nursing home official, usually a nurse. We asked the nurses to provide us with their opinion as to how each beneficiary would have been transported if he or she had to travel away from the home for the test. These beneficiaries may better reflect the need for ambulance services by most nursing home beneficiaries. From our sample, we determined that about 50 percent of the beneficiaries who received an EKG test and 40 percent of the beneficiaries who received an ultrasound test would most likely have been transported by ambulance if the tests had been done outside the nursing home. Most of the beneficiaries who the nurses believed would have needed an ambulance were totally bedridden. The concern generating the order for the test had been either that an episode developed late at night or that a condition was serious enough to border on a call to 911. Beneficiaries whom the nurses believed could be transported by means other than an ambulance were usually ambulatory and their medical situations generally involved a

[9]We were unable to verify whether the place of service coded on each claim was reported correctly. For example, we found a number of claims coded as being performed in an independent laboratory setting with transportation payments being made. In 1995, the data show that 86,420 EKG and 60,320 ultrasound services were done in this setting, of which about 4,300 and 3,200 transportation payments were made, respectively. Either these claims were improperly coded (should have been coded as nursing facilities) or the transportation payments should not have been made. Even if all these claims were improperly coded and should have been shown as being done in a nursing home, it would only increase the range between savings and costs and it would not affect our conclusion.

scheduled service done 1 or 2 days after the order or a baseline test requested upon entering the home.[10]

We discussed HCFA's policy with HCFA officials, representatives of organizations representing portable x-ray suppliers, independent physiological laboratory providers, and several individual providers of EKG and ultrasound services. Also, we sought the opinions of several medical associations, including the American College of Cardiology, the American College of Physicians, and the American College of Radiology. In addition, we solicited comments from 11 health care associations.

In estimating the potential net cost to Medicare from eliminating transportation payments, we did the following: (1) identified, from the sample 5-percent national claims data file, the Medicare beneficiary population that received an EKG or ultrasound service from a provider that was paid a transportation fee for delivering the service; (2) reduced this count by the beneficiaries who also had an x-ray service (since the provider would continue to get transportation fees for the x-ray), the beneficiaries who had the service delivered by a provider who could not be paid transportation expenses, and beneficiaries receiving the services while covered under posthospital extended care; (3) estimated the percentage of beneficiaries who would have been transported by ambulance (using our observations from case files in two states); (4) developed an average ambulance fee paid in each state (using data on the skilled nursing home beneficiaries who went by ambulance in 1995 to an outpatient facility for a diagnostic test); and (5) determined the transportation fee paid to mobile providers in each state.

[10]There is a question as to whether Medicare would pay for a test that is performed only to establish a baseline reading, without there being some indication of medical necessity.