

3 | Provider Rates

Overview

As discussed in Chapter 1 of this Handbook, budgetary pressures are spurring policymakers at every level to examine the drivers of high spending. In 2018, spending on hospitals and physicians accounted for [33 and 20 percent](#) respectively of U.S. national health expenditures (NHE) – or, over half of all health care spending (See Fig.3.1). Further, a [recent analysis](#) found that the U.S. spends an average of \$6,624 per person on inpatient and outpatient services compared to \$2,718 per person in comparable countries. This trend exists [despite](#) the U.S. having shorter average hospital stays and fewer physician visits per capita. Thus, a comprehensive discussion of health care spending must examine spending on, and payment rates for, hospital and physician services.

For various reasons, rates for the same service can vary significantly across Medicare, Medicaid, and commercial plans, and also across states and regions. Additionally, underpayment for some services such as primary care, and overpayment for others, is a recurring issue. The impacts of high health spending and irregular provider rates are often felt most acutely by individuals and households through higher out-of-pocket costs or [unexpected bills](#) (so-called “surprise billing”). As health care spending rises and consumer issues come into sharper focus on the national stage, states and federal agencies are interested in understanding provider rates and the outcomes we pay for.

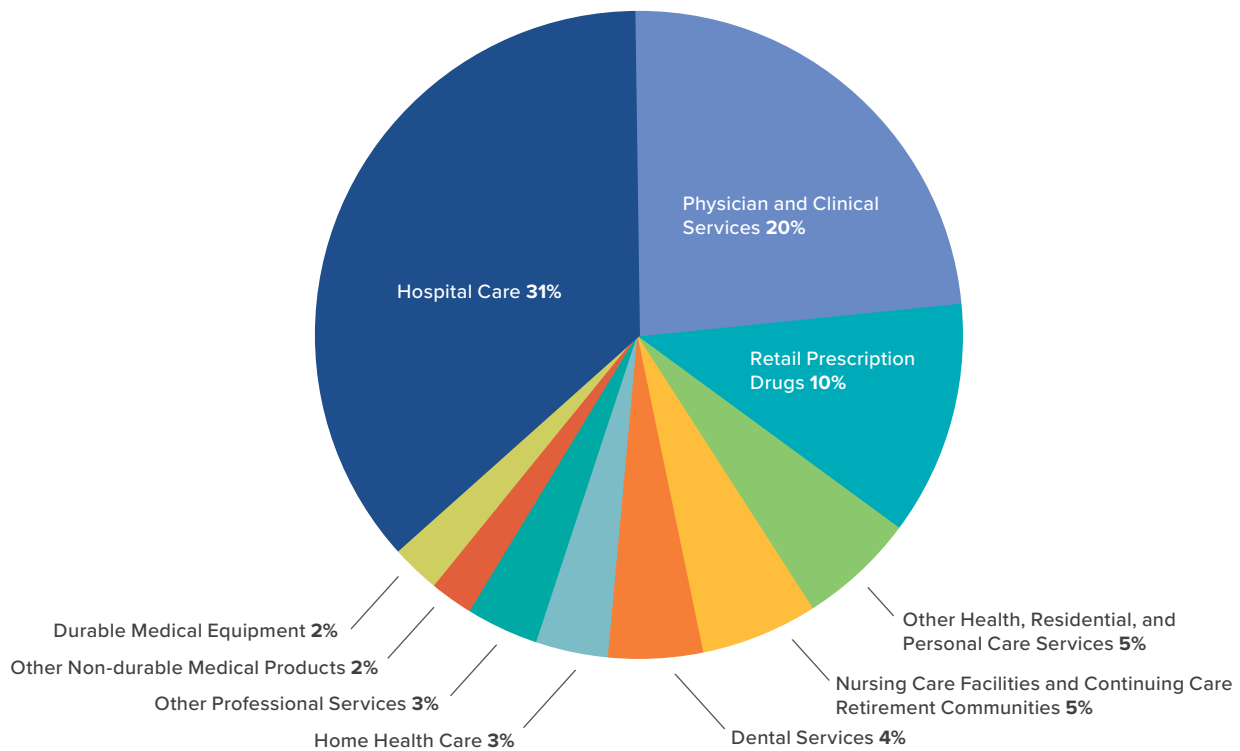
Provider Payments in Medicare

“Health care provider” is a broad term that encompasses the various people, entities, or companies that deliver a health care service to patients. These may include nurses, medical equipment, outpatient

surgery clinics, etc. This Handbook focuses primarily on hospital and physician payments.

The Medicare program relies primarily on fee-for-service (FFS) payments to hospitals and physicians made

Figure 3.1 Health Spending by Type of Service or Product (2019)



Source: “National Health Expenditures 2019 Highlights.” U.S. Centers for Medicare & Medicaid Services. December 16, 2020. Available at <http://allh.us/N9bM>.

through prospective payment systems. The Centers for Medicare and Medicaid Services (CMS) establishes a base payment rate for a unit of service. The hospital and physician payment systems – formally named the [Inpatient Prospective Payment System](#) (IPPS), the [Outpatient Prospective Payment System](#) (OPPS), and the [Medicare Physician Fee Schedule](#) (MPFS) – are updated annually through a notice of proposed

rulemaking (NPRM) process. These rules are usually submitted in the spring and summer for a comment period, and finalized in the fall. Implementation for these rules is meant to start the next fiscal year or calendar year, depending on the rule’s schedule.¹ Together, [these systems](#) establish how much Medicare will pay for more than 745 hospital diagnosis-related groups (DRGs) and 8,000 [HCPCS/CPT](#) codes.

GLOSSARY OF TERMS

Inpatient Care: Treatment received only when a physician formally admits someone to a typically more specialized health care entity such as a hospital. Inpatient status ends when a physician formally discharges the patient.

Outpatient Care (or Ambulatory Care): Clinics, doctor’s offices, urgent care centers, walk-in labs, and ambulatory surgery centers are considered outpatient settings. Care in an emergency department is usually considered outpatient, even though they are typically connected to a hospital.

Hospital Inpatient Services vs. Hospital Outpatient Services: Hospital inpatients typically are severely ill or have suffered severe trauma. Still, inpatients can receive more routine services such as non-emergency surgeries, x-rays, and infusion therapies. Conversely, people can obtain more routine care ([such as diagnostic and treatment services](#)) at a hospital, but be considered outpatients. The admittance distinction impacts how insurance plans will [pay for them](#). Inpatient care is usually more expensive than outpatient care.

In-Network: The facilities, providers, and suppliers a health insurer or plan has contracted to provide health care services. These entities are only considered in-network for a given insurance plan as payers create their own networks on a plan by plan basis.

Out-of-Network: Any facility, provider, or supplier that has not formally contracted with an insurer or accepted their negotiated rates. These providers are typically [more expensive](#) than in-network providers.

Fee-for-Service (FFS): Payment system in which clinicians and facilities are paid for each service performed and do not typically account for care management or coordination. The majority of the U.S. health care system is based on FFS payments.

Value-Based Payments (VBP): Payment systems that attempt to move away from the FFS system and pay providers based on quality, cost of care, and other outcome metrics. There are various [approaches](#) and [demonstrations](#), including pay-for-performance and alternative payment models (APMs).

¹Medicare rules are either fiscal year or calendar year rules. For example, IPPS is effective October (fiscal year) and OPPS is effective January 1 (calendar year).

Underpayment for some services such as primary care, and overpayment for others, is a perennial issue.

However, underpayment for some services such as primary care, and overpayment for others, is a perennial issue. Given that these annual rules affect many health care stakeholders, they are contentious, as small updates or revaluing of services can change total expenditures by billions. Medicare payment changes occur via regulation and within the parameters that Congress passed to establish the payment systems. Stakeholders approach congressional staff to discuss the impacts of proposed payment changes on providers, services, and technologies – and place pressure on CMS to advance or pull back proposed changes – or even to reverse or delay payment changes via legislation.

Note that in 2015 Congress passed the Medicare Access and CHIP Reauthorization Act ([MACRA](#)) that established two new “[pathways](#)” or methodologies for calculating payment updates for physician services: the Merit-Based Incentive Payment System (MIPS) and the Advanced Alternative Payment Model (APM). While both aim to gradually link payment to the value of care delivered, the programs have been difficult to implement and may significantly reduce physician payments in the coming few years. If this is the case, physicians and other stakeholders are likely to continue pushing Congress to intervene – either to hold or blunt the cuts’ impacts in MIPS or extend bonus opportunities for those in the Advanced APM pathway.

While less is known about payment rates for hospitals and providers participating in the Medicare Advantage (MA) program, recent studies have found that they

generally mirror those of Medicare FFS. Experts attribute this to several facts, including MA plan rates are based on Medicare FFS spending, restrictions against balance billing for MA patients treated by out-of-network providers, and greater acceptance among plans, [hospitals](#), and [providers](#) of alignment in rates across the two. With [one in three](#) Medicare beneficiaries joining Medicare Advantage plans, changes to the program and provider payment rates can have significant budgetary impacts.

For more information on how Medicare provider payment functions, visit Medicare Payment Advisory Commission (MedPAC)’s [Payment Basics](#) page.

Provider Payments in Medicaid

States have significant flexibility in setting provider payment rates in their Medicaid programs, yet there are general federal requirements. [Rates](#) must be consistent with the efficiency, economy, and quality of care, and be sufficient to supply access to care and benefits equivalent to the general population in the same geographic area. Payments can be made either through FFS, in which providers are paid directly for services received by beneficiaries, or through managed care plans, in which states pay managed care

plans for each beneficiary enrolled in the plan. The managed care plan then pays providers for the services they deliver to beneficiaries. While [over 80%](#) of Medicaid beneficiaries receive some benefits or care through managed care, the majority of high-cost populations and delivery of high-cost services still occurs in FFS. Thus the majority of state spending still occurs through FFS arrangements.

[Under FFS](#), states use various methods (approved by CMS) to set inpatient payment rates, including reimbursement based on reported costs, number of hospital days, or diagnosis-related groups (DRGs). States have the latitude to set payments for physician services, with most using a fee schedule as with Medicare and commercial payers. In addition, states also make [supplemental payments](#) in both FFS and managed care systems that are both separate and on top of services rendered. These payments aim to support quality or

delivery system reform initiatives or may attempt to adjust total reimbursement for facilities that serve a complex patient population (rural or safety-net).

The Medicaid and CHIP Payment and Access Commission (MACPAC) [estimated](#) that, on average, Medicaid FFS physician payment rates are two-thirds that of Medicare payment rates. As a result, there have been long-standing concerns that low Medicaid payment rates discourage provider participation in the program and can limit beneficiary access to care. However, once supplemental payments for hospitals and nursing facilities are taken into account, the ratio of Medicaid to Medicare payments [evens out](#), and, in some states, Medicaid payment to hospitals may be higher.

For more information on how Medicaid provider payment functions, visit MACPAC's [Provider Payment](#) and [Delivery Systems](#) pages.

KEY PROVIDER PAYMENT ISSUES FOR THE 117TH CONGRESS

- During COVID-19, Congress and the Administration took steps to **make telemedicine more accessible** by increasing payment rates for remote care and offering [regulatory flexibilities](#). Providers and patient advocates are pushing for many of these changes to be retained indefinitely. However, Congress will likely weigh how to balance expanding access to telehealth with concerns about waste, fraud, and abuse.
- Conversely, several issues across the next two years could increase scrutiny over **how provider payment rates are set and how they could be limited**, including federal and state budget pressures, the Medicare Hospital Trust Fund's potential [insolvency](#), and calls for greater transparency about the results of the [emergency financial aid](#) given to provider entities during the pandemic.
- Appeals from constituents and patient advocates are likely to intensify about **addressing high consumer out-of-pocket costs** beyond surprise billing, including lowering premiums, co-pays, and deductibles. Some policy approaches to reduce out-of-pocket costs involve reducing or capping provider and hospital rates.
- Data demonstrating **a growing differential between commercial, Medicare, and Medicaid provider payment rates** and consolidation as a primary driver will pressure policymakers to examine federal policy levers that could address these issues across all markets.

Provider Payments in Commercial Plans

Commercial plans set payment rates for providers primarily through negotiation with providers in a given region. While many commercial payers have based their payment systems – and even payment levels – on Medicare, several factors influence negotiated payment rates. These include the number of enrollees in the plan (their market share), geography, and relative size, or market concentration, of payers versus hospitals and physician practices in a given area. A market with one or two dominant insurers will have more negotiating power for lower rates relative to a different market with several payers and a more dominant health system with the ability to negotiate higher payment rates.

Historically, payment rates between commercial plans and providers are also not usually public. [Experts note](#) that this can impede the identification of high-value providers and can contribute to price increases without public scrutiny. For years, states have been implementing [all-payer claims databases](#) (APCDs) to advance cost transparency, better understand geographic variations in price and utilization, and track healthcare spending trends, among other goals. APCDs are [large databases](#) used to collect medical, pharmacy, and usually dental claims, as well as eligibility and provider files from private and public payers. Nearly [20 states](#) have APCDs, with five more in the implementation phase. Yet data collected is typically incomplete, as only a handful of these state APCDs make the data public, and states cannot require federally regulated plans – typically large employer plans – to submit data. State cost transparency efforts are growing – and will continue to influence congressional discussions on price transparency for providers.

For more information about how commercial plan provider payment functions, see this Congressional Research Service [report](#), as well as this America's Health Insurance Plans' [Guide to Understanding Health Plan Networks](#).

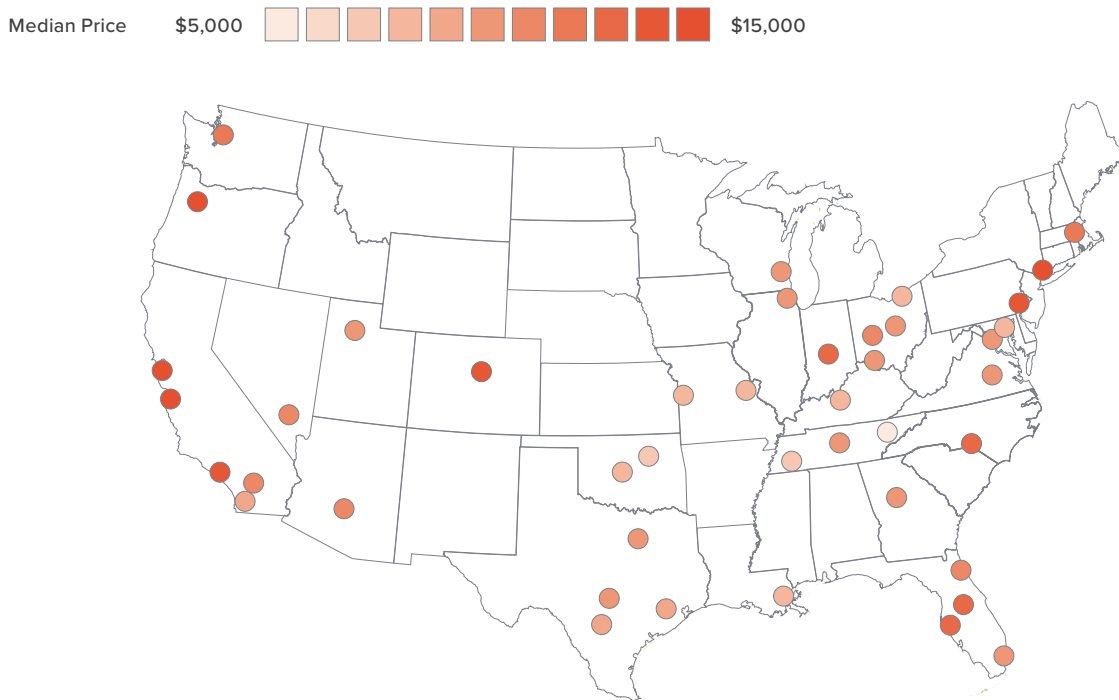
Given the various factors that can affect commercial plan and provider negotiations, there is significant variability in payment rates depending on a market's characteristics.

Provider Rate Disparities Between Private and Public Payers

Given the various factors that can affect commercial plan and provider negotiations, there is significant variability in payment rates depending on a market's characteristics. A [2020 study](#) by the Health Care Cost Institute found that the average commercial costs for medical professional services range from 98% of Medicare in Alabama to 188% of Medicare in Wisconsin. Across the country, prices paid for inpatient and medical care have been rising rapidly. Among large employer plans, the cost of inpatient admissions for

Figure 3.2: Example of Price Variation Across Metropolitan Areas (C-Section Delivery, 2017)

C-section delivery prices varied from \$5,142 (Knoxville, TN) to \$21,890 (San Francisco, CA).



Source: "Past the Health Marketplace Index, Volume 1: Exploring the Actual Prices Paid for Specific Services by Metro Area." Kennedy, K., Clayton, E., Johnson, B., et al. Health Care Cost Institute. November 2020. Available at <http://allh.us/URXM>.

surgical care almost doubled from \$25,054 to \$47,345 from 2008 to 2018 and from \$11,545 to \$21,395 for medical care over the same time period. While prices are rising everywhere, they vary widely (See Fig. 3.2). For example, the average cost of an inpatient admission for those in large employer plans ranged from \$18,392 in St. Louis to \$31,744 in San Diego.

A recent study also examined the relationship between Medicare and commercial physician payments and estimated that a \$1.00 increase in Medicare payments was associated with a \$1.16 increase in commercial payments to physicians. The study illustrated the impact of Medicare on commercial payments and underscores why policymakers often view the Medicare program as a lever for commercial market changes. Neither growth in provider rates nor geographic variations in costs are

new – but the pressure may be greater than before given the impacts on all markets and individual and family premiums and cost-sharing.

The price differential among payers – with commercial rates being higher than Medicare and Medicaid – has been studied extensively, especially in the hospital sector. However, there are concerns that the disparities in payments have increased in recent years (See Fig. 3.3). A study of ESI plans recently found that in 2017, employers and private insurers paid 247% of what the Medicare program would have paid for services at the same facilities – up from 224% in 2016 and 230% in 2017. These studies may increase calls for price transparency or an examination of how Medicare can be a lever to reduce differentials between government and commercial rates.

State and Federal Policy Activity on Provider Costs

The last few years have seen an increase in state activity and national discussion on hospital and physician pricing. States have been more active on the issue and are implementing several policy changes. Policy approaches fall into broad themes, including market-based policies, consumer transparency efforts, and shifting to pay for performance or value-based payment systems.

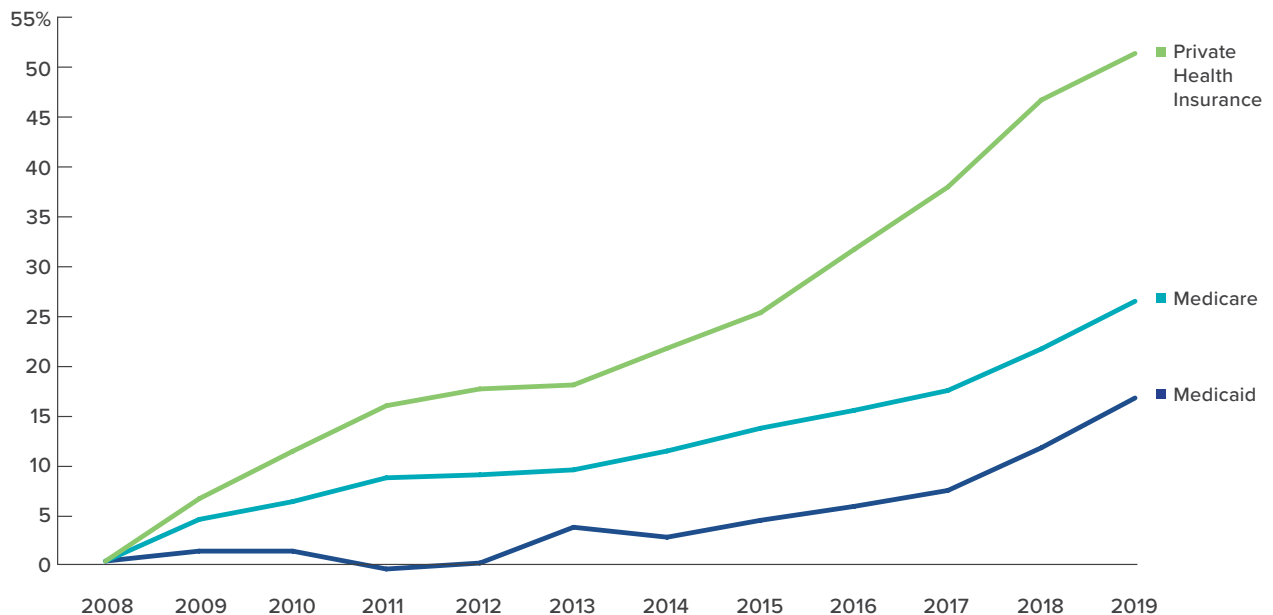
Some states have been working with CMS and the Center for Medicare & Medicaid Innovation (CMMI) to

address high spending by shifting payments systems to [value-based models](#). These initiatives attempt to, among other things, pay providers based on the total cost of care and/or outcomes metrics. [Maryland](#) is the only state in the country to use an all-payer rate-setting system for hospital services, which has evolved considerably since its inception in the 1970s. States are also using the Affordable Care Act Marketplaces to address provider pricing via public options – although their design varies widely from state to state. [Washington](#) is the first state to implement a public option-type approach, which caps provider and facility payments at 160% of Medicare costs (excluding pharmacy benefits).

[Health care market consolidation](#) (i.e., mergers, acquisitions, and other affiliations that reduce the number of competitors in a health care market) is often cited as

Fig 3.3 Cumulative Growth in Per Enrollee Spending by Private Insurance, Medicare, and Medicaid (2008–2019)

On a per enrollee basis, private insurance spending has grown much faster than Medicare and Medicaid spending.



Source: “How has U.S. Spending on Health Care Changed Over Time?” Kamal, R., McDermott, D., Ramirez, G., et al. Peterson - KFF Health System Tracker. December 23, 2020. Available at <http://allh.us/njYK>.

a noteworthy driver of hospital and physician pricing issues. [Examples of state options](#) to address the impacts of provider consolidation include, collecting data via APCDs, creating [independent](#) or [multi-agency](#) review commissions, controlling costs by restricting facility fees, and tying rates for public purchasers to Medicare rates.

While state initiatives and experimentation are essential, policy discussions and changes must occur at both levels. State policymakers may better understand local market considerations, but lack some of the broader policy levers and options available to the federal government.

At the national level, recent congressional and administrative approaches have focused on increasing [price transparency](#) and addressing “surprise bills.” In [2019-2020](#), one in five insured individuals received a “surprise bill” or unexpected bill from an out-of-network provider, which spurred greater scrutiny over provider payment practices. Debate throughout the 116th Congress led to surprise billing legislation passing at the very end of 2020. The [new law](#) prohibits providers from billing patients more than in-network cost-sharing for emergency and specific non-emergency care. Despite these new protections, ongoing discussions about addressing higher out-of-pocket costs more generally in the form of premiums, copays, and deductibles are likely to intensify.

On January 1, 2021 – after [extensive litigation](#) from the hospital industry – a new CMS rule on [hospital price transparency](#) took effect requiring hospitals to publish consumer-friendly lists of their charges for their 300 most “shoppable services” – including minimum and maximum rates negotiated with private payers. The rule applies to hospitals, excluding ambulatory surgery centers and individual providers not employed by a hospital. Additionally, in October 2020, a [complementary rule](#) was finalized imposing new transparency requirements on most group health plans (employer-sponsored health plans) and health insurers in the individual and group markets. Congress and CMS will face ongoing pressure to strengthen the enforcement of these rules and broaden its scope.

These state and federal actions will influence future policymaking – at least with continued calls for measures to address out-of-pocket costs. If Congress feels the pressure to respond to rising costs for commercially and publicly insured patients, then efforts could broaden for federal policymakers to identify options to address pricing issues by leveraging Medicare, the ACA Marketplaces, or other national oversight mechanisms.

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RESOURCES

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OVERVIEW

National Health Expenditures 2019 Highlights.
<http://allh.us/N9bM>

What Drives Health Spending in the U.S. Compared to Other Countries. <http://allh.us/T8mM>

US Statistics on Surprise Medical Billing.
<http://allh.us/Hhe8>

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Acute Inpatient PPS. <http://allh.us/Wjah>

Hospital Outpatient PPS. <http://allh.us/hBpr>

Physician Fee Schedule. <http://allh.us/VFwn>

Paths to Healthcare Payment Reform: Setting Payment Levels. <http://allh.us/CxAM>

Code List for Certain Designated Health Services (DHS).
<http://allh.us/6gFa>

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA; P.L. 114-10). <http://allh.us/ekGf>

Quality Payment Program Overview. <http://allh.us/mcf6>

An Analysis of Private-Sector Prices for Hospital Admissions. <http://allh.us/vMxp>

Physician Reimbursement in Medicare Advantage Compared With Traditional Medicare and Commercial Health Insurance. <http://allh.us/jkvB>

Medicare Advantage. <http://allh.us/rCMx>

Payment Basics. <http://allh.us/rYvH>

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MACPAC: Provider Payment and Delivery Systems.
<http://allh.us/nVGD>

MACPAC: Provider Payment Under Fee for Service.
<http://allh.us/k3nD>

Medicaid Supplemental Payments. <http://allh.us/dXby>

Medicaid Hospital Payment: A Comparison across States and to Medicare. <http://allh.us/XWGV>

PROVIDER PAYMENTS IN COMMERCIAL PLANS

Paths to Healthcare Payment Reform: Setting Payment Levels. <http://allh.us/CxAM>

Informing Health System Change – Use of All-Payer Claims Databases. <http://allh.us/AEtd>

The Basics of All-Payer Claims Databases.
<http://allh.us/fB9F>

Interactive State Report Map. <http://allh.us/UqkY>

Surprise Billing in Private Health Insurance: Overview and Federal Policy Considerations. <http://allh.us/kTwX>

A Consumer Guide to Understanding Health Plan Networks. <http://allh.us/BwYD>

PROVIDER RATE DISPARITIES BETWEEN PRIVATE AND PUBLIC PAYERS

Health Care Cost Institute: Wide Variation in Commercial Prices vs. Medicare Rates Across & Within U.S. States.
<http://allh.us/6PWq>

How Costly Are Common Health Services in the United States? <http://allh.us/JC94>

In the Shadow of a Giant: Medicare's Influence on Private Physician Payments. <http://allh.us/XYJc>

Nationwide Evaluation of Health Care Prices Paid by Private Health Plans. <http://allh.us/GfVJ>

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Engrossed Substitute Senate Bill 5526. <http://allh.us/pPyw>

Addressing Consolidation in the Healthcare Industry.
<http://allh.us/HJ7T>

State Policies to Address Vertical Consolidation in Health Care. <http://allh.us/E8JM>

Commissioning Change: How Four States Use Advisory Boards to Contain Health Spending. <http://allh.us/dqDY>

A Lesson from States: Curtailing Anticompetitive Health Care Consolidation. <http://allh.us/xhrw>

Price Transparency: Requirements for Hospitals and Health Plans. <http://allh.us/J7hx>

US Statistics on Surprise Medical Billing.
<http://allh.us/Hhe8>

Unpacking the No Surprises Act: An Opportunity to Protect Millions. <http://allh.us/crPF>

Trump Administration Finalizes Transparency Rule for Health Insurers. <http://allh.us/DmGt>

Hospital Price Transparency. <http://allh.us/Uh9C>

Transparency in Coverage Final Rule Fact Sheet (CMS-9915-F). <http://allh.us/P9Jr>

Box: Glossary of Terms

Outpatient Hospital Services. <http://allh.us/fJFR>

Are You a Hospital Inpatient or Outpatient?
<http://allh.us/GPF3>

Glossary of Health Coverage and Medical Terms.
<http://allh.us/j9Wc>

Alternative Payment Models: The APM Framework.
<http://allh.us/yUq7>

Innovation Models. <http://allh.us/8fxK>

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Pandemic Flexibilities in Long-Term Care.
<http://allh.us/Jykm>

Medicare Solvency Projections and Potential Policy Solutions. <http://allh.us/9qqA>

An Expert Discussion on the Provider Relief Fund.
<http://allh.us/GDPb>