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Medicare: Payments to Physicians

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Summary

Payments for physicians services under Medicare are made on the basis of a fee schedule. This fee schedule, established by the Omnibus Budget Reconciliation Act of 1989 (OBRA 1989), went into effect January 1, 1992. The fee schedule is intended to relate payments for a given service to the actual resources used in providing that service.

The fee schedule assigns relative values to services. These relative values reflect physician work (i.e., the time, skill, and intensity it takes to provide the service), practice expenses and malpractice costs. The relative values are adjusted for geographic variations. The adjusted relative values are then converted into a dollar payment amount by a conversion factor. The law provides a specific formula for calculating an annual update in the payment amount. Medicare payments for physicians services (excluding those provided under managed care arrangements) totaled an estimated $30.7 billion in FY1997.

The Balanced Budget Act of 1997 (BBA 97) included savings in payments to physicians and other practitioners of $4.5 billion over the FY1998-FY2002 period. These savings are achieved by providing for the use of a single (rather than three) conversion factors and limiting the annual update in the conversion factor to the growth rate in the economy as a whole.

Many physicians have evidenced concern regarding the scope of recent changes. Changes in calculation of the conversion factor coupled with changes in practice expense calculations will have the greatest impact on payments for surgical services. For example, the Health Care Financing Administration (HCFA, the agency that administers Medicare) has estimated that Medicare payments in 1998 will drop by over 5% for cardiac surgeons, thoracic surgeons, neurosurgeons and ophthalmologists. Conversely, the payments are expected to increase by over 5% for internists and family practice physicians. The reductions in payments for surgical services are expected to further decline as a new methodology for paying for practice expenses is implemented over the 1999-2002 period.

Some observers have suggested that as Medicare places additional constraints on spending, access to care may be impeded. To date, this has not been the case. It should be noted that the Medicare program is not alone in attempting to constrain cost increases. Private insurers and employers are also attempting to control spending through various approaches including an increased emphasis on managed care.

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Medicare: Payments to Physicians

Introduction: Medicare Fee Schedule

Why Fee Schedule Was Enacted

Payments for physicians services under Medicare are made on the basis of a fee schedule. This fee schedule, established by the Omnibus Budget Reconciliation Act of 1989 (OBRA 1989), went into effect January 1, 1992. The physician fee schedule replaced the reasonable charge payment method which, with minor changes, had been in place since the implementation of Medicare in 1966. Observers of the reasonable charge system cited a number of concerns including the rapid rise in program payments and the fact that payments frequently did not reflect the resources used. They noted the wide variations in fees by geographic region; they also noted that physicians in different specialties could receive different payments for the same service. The system was also criticized for the fact that while a high price might initially be justified for a new procedure, prices did not decline over time even when the procedure became part of the usual pattern of care. Further, it was suggested that differentials between recognized charges for physicians visits and other primary care services versus those for procedural and other technical services were in excess of those justified by the overall resources used.

The fee schedule was intended to respond to these concerns by beginning to relate payments for a given service to the actual resources used in providing that service. The design of the fee schedule reflected many of the recommendations made by the Physician Payment Review Commission (PPRC), a congressionally established advisory body.

Calculation of Fee Schedule

The fee schedule has three components: the *relative value* for the service; a *geographic adjustment*, and a national dollar *conversion factor*.

Relative Value. The relative value for a service compares the relative physician work involved in performing one service with the work involved in providing other physicians' services. It also reflects average practice expenses and malpractice expenses associated with the particular service. Each physician service is assigned its own relative value. The scale used to compare the value of one service with another is known as a resource-based relative value scale (RBRVS).

The relative value for each service is the sum of three components: (1) the *physician work component*, which measures physician time, skill, and intensity in providing a service; (2) the *practice expense component*, which measures average

practice expenses such as office rents and employee wages; and (3) the *malpractice expense component*, which reflects average insurance costs.

Geographic Adjustment. The geographic adjustment is designed to account for variations in the costs of practicing medicine. A separate geographic adjustment is made for each of the three components of the relative value unit, namely a work adjustment, a practice expense adjustment, and a malpractice adjustment. These are added together to produce an indexed relative value unit for the service for the locality. There are 89 service localities nationwide in 1998.

Conversion Factor. The conversion factor is a dollar figure that converts the geographically adjusted relative value for a service into a dollar payment amount. The conversion factor is updated each year. In 1997, there were three conversion factors: one for surgical services; one for primary care services; and one for all other services.

BBA 97 provided for the use of a single conversion factor beginning in 1998. The 1998 conversion factor is $36.6873. Thus, the payment for a service with an adjusted value of 2.2 will be $80.71. Anesthesiologists are paid under a separate fee schedule which uses base and time units; a separate conversion factor ($16.8762 in 1998) applies.

The use of a single conversion factor reflects recommendations made by the PPRC. The PPRC was replaced by the Medicare Payment Advisory Commission (MedPAC) on September 30, 1997; it is responsible for advising the Congress on the full range of Medicare payment issues.

Beneficiary Protections

Medicare pays 80% of the fee schedule amount for physicians' services after beneficiaries have met the $100 annual deductible. Beneficiaries are responsible for the remaining 20%, which is referred to as coinsurance. A physician may choose whether or not to accept **assignment** on a claim. In the case of an assigned claim, Medicare pays the physician 80% of the approved amount. The physician can only bill the beneficiary the 20% coinsurance plus any unmet deductible. When a physician agrees to accept assignment of all Medicare claims in a given year, the physician is referred to as a **participating physician**. Physicians who do not agree to accept assignment on *all* Medicare claims in a given year are referred to as **nonparticipating physicians**. There are a number of incentives for physicians to become participating physicians, chief of which is that the fee schedule payment amount for nonparticipating physicians is only 95% of the recognized amount for participating physicians.

Nonparticipating physicians may charge beneficiaries more than the fee schedule amount on nonassigned claims; these **balance billing** charges are subject to certain limits. The limit is 115% of the fee schedule amount for nonparticipating physicians (which is only 9.25% higher than the amount recognized for participating physicians i.e., 115% x .95 = 1.0925).

During 1996, 77.5% of physicians (and limited licensed practitioners) billing Medicare were participating physicians. Over 94% of Medicare physician charges were billed by participating physicians; further, 98% of charges were billed on an assigned basis. The percentage of participating physicians increased to 80.2% in 1997.

Calculation of Annual Update to the Fee Schedule

As noted, the conversion factor is a dollar figure that converts the geographically adjusted relative value into a dollar payment amount. This amount is updated each year according to a formula established by law. BBA 97 changes the calculation, beginning in 1998. This section provides a brief overview of how this calculation is made. Following that is a discussion of some of the concepts underlying the calculation.

Update Calculation

Calculation for 1992-1997. The law specified that the annual update would equal inflation plus or minus the spending growth rate in a prior period compared to a target growth rate known as the Medicare volume performance standard (MVPS). Specifically, the update equaled the Medicare economic index (MEI, which measures inflation) plus or minus the difference between the MVPS for the second preceding fiscal year and actual expenditures for that year. (Thus, FY1995 data was used in determining the calendar year 1997 update.) However, regardless of actual performance during the base period, there was a limit on the actual reduction (but not increase).

Initially, there was one conversion factor. Beginning in 1994, three calculations were made and three conversion factors were used (one for surgical services, one for primary care services, and one for other services). Congress frequently provided for a reduction in the update that would otherwise have applied under the law. (See **Table 1** for a history of the update).

Calculation for 1998 and Future Years. BBA 97 changed the calculation of the update. It provided for a single conversion factor beginning in 1998. It specified that the 1998 amount was to be the weighted average of the three 1997 conversion factors updated to 1998. The Health Care Financing Administration (HCFA) announced that the 1998 conversion factor is $36.6873.

Beginning in 1999, the update percentage will equal the MEI subject to an adjustment to match target spending under the sustainable growth rate system (which replaces the MVPS). This adjustment will set the conversion factor at a level so that projected spending for the year will meet allowed spending by end of the year. Allowed spending for the year is calculated using the sustainable growth rate (see below).[1] However, in no case can the conversion factor update be more than three

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[1]The adjustment is calculated as follows. The adjustment is determined by estimating the difference between: (a) cumulative allowed spending for April 1, 1997 through March 31 of the year involved; and (b) the cumulative sum of actual spending for April 1, 1997 through March 31 of the previous year. This amount is divided by actual expenditures for the 12-month period ending March 31 of the preceding year, increased by the sustainable growth rate for the fiscal year which begins during such 12-month period. For the 12-month period ending March 31, 1997 allowed expenditures are defined as actual expenditures for the period. For subsequent 12-month periods, allowed expenditures equal the previous

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percentage points above the MEI or more than seven percentage points below the MEI.

Target Growth Rate

The fee schedule specifies a limit on payments per service; however, it does not place a limit on the volume of services, and thus, overall Medicare expenditures for physicians services. The MVPS, and subsequently the sustainable growth rate, is intended to serve as a restraint on overall Medicare spending. Both the MVPS and the sustainable growth rates are calculated on a fiscal year basis.

FY1991-FY1997: MVPS. The MVPS for a year was based on estimates of several factors (changes in fees, fee-for-service enrollment, volume and intensity, and laws and regulations). This produced a rate of spending growth that would be expected to occur if physicians continued to practice as they had previously. The MVPS derived from this calculation was subject to a reduction which was known as the *performance standard factor*. The performance standard factor for FY1997 was four percentage points. The performance standard factor slowed the rate of growth in the MVPS and by extension, the annual update.

FY1998-Sustainable Growth Rate. The sustainable growth rate system replaces the MVPS. The annual sustainable growth increase is calculated using the same factors as the MVPS, except that the factor for historical growth in volume and intensity is replaced with projected annual growth in real gross domestic product. HCFA announced that the FY1998 sustainable growth rate is 1.5%. This increase reflects an estimated 2.3% increase in fees, a 2.4% decline in fee-for-service enrollment (which reflects the movement of more beneficiaries into managed care), an estimate of 1.1% growth in the gross domestic product; and a 0.6% increase attributable to changes resulting from changes in laws and regulations. The FY1998 sustainable growth rate will be used in the calculation of the 1999 update to the conversion factor.

Difference Between MVPS and Sustainable Growth Rate

The sustainable growth rate system is quite different from the MVPS. Under the MVPS system, a new MVPS was calculated each year, and the conversion factor update for a year was based on the success in meeting the target in a prior period. The sustainable growth rate system looks at *cumulative* spending since the base year period ending March 31, 1997. The calculation of the conversion factor update for a year is based on a comparison of *cumulative* allowed spending since the base period (as determined by updates in the sustainable growth rate) with actual spending since the base period. The conversion factor is set at a level so that projected spending by the end of the year will equal allowed spending by the end of the year. The conversion factor update would be lower than the MEI if cumulative actual spending were expected to exceed cumulative allowed spending by the end of the year and

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[1](...continued)
year's amount, increased by the sustainable growth rate for the fiscal year beginning during such 12-month period.

higher if such spending were expected to be lower than the allowed amount. The law limits the variance in a single year to 3 percentage points above inflation and 7 points below inflation. Any larger variance would be made up in subsequent periods.

Reasons for BBA 97 Changes

The change to a single conversion factor and use of a sustainable growth rate system was recommended by PPRC after an extensive review of the prior system.

PPRC had identified a number of methodological problems with the calculation of the MVPS. Determining an allowance for historical growth in volume and intensity proved difficult. HCFA used a 5-year average historical growth rate. Use of this rate initially resulted in artificially high MVPS numbers, particularly for surgical services. In turn, this meant that it was relatively easy for physicians to keep spending below the targets and thus receive higher increases in the conversion factors in subsequent years. However, over time, the 5-year trend in volume and intensity growth fell. At the same time the amount of the performance standard reduction grew to four percentage points. As a result, the rate of growth in the MVPS, and by extension the annual increase in the conversion factors slowed. **Table 1** shows the relatively large increases in the conversion factors for surgical services in 1994 and 1995, these increases dropped significantly in 1996 and 1997. In 1996, the primary care conversion factor actually dropped; in 1997, the non-surgical conversion factor dropped. These trends were expected to be exacerbated in subsequent years. In 1997, PPRC noted that the MVPSs which were originally well above the annual increases in the gross domestic product were projected to drop well below these increases in future years.[2]

PPRC and others also observed that multiple conversion factors had led to distortions in payments. Some viewed the larger updates for surgical services as contrary to the goals of the fee schedule payment system which was intended to increase payments for primary care services. Observers also suggested that the use of a cumulative sustainable growth rate, based on the growth in the economy as a whole, was a more appropriate way to constrain expenditures over time. However, PPRC had recommended that 1 or 2 percentage points should be added to gross domestic product growth to allow for advances in medical capabilities. BBA 97 does not include an additional amount.

The move to a single conversion factor, coupled with other changes in BBA 97, will result in overall program savings. However, the impact of the changes will differ by specialty with primary care services generally experiencing an increase compared to what would have occurred in the absence of the legislation and surgeons generally experiencing a decrease. This impact is discussed further in the Issues chapter (see below).

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[2]Physician Payment Review Commission. Annual Report to Congress, 1997.

Table 1. Conversion Factors: Calculation of Annual Updates, 1992-1998

	Calculation of update: MEI + MVPS adjustment + legislative adjustment (in %)				
	MEI	MVPS adjustment	Legislative adjustment	Update	Conversion factor
CY1992					
All services	3.2	-0.9	-0.4	1.9	$31.00
CY1993					
Surgical	2.7	0.4	NA	3.1	31.96
Non-surgical	2.7	-1.9	NA	0.8	31.25
CY1994					
Surgical	2.3	11.3	-3.6	10.0	35.16
Primary care	2.3	5.6	0.0	7.9	33.72
Non-surgical	2.3	5.6	-2.6	5.3	32.90
CY1995					
Surgical	2.1	12.8	-2.7	12.2	39.45
Primary care	2.1	5.8	0.0	7.9	36.38
Non-surgical	2.1	5.8	-2.7	5.2	34.62
CY1996					
Surgical	2.0	1.8	NA	3.8	40.80
Primary care	2.0	-4.3	NA	-2.3	35.42
Non-surgical	2.0	-1.6	NA	0.4	34.62
CY1997					
Surgical	2.0	-0.1	NA	1.9	40.96
Primary care	2.0	0.5	NA	2.5	35.77
Non-surgical	2.0	-2.8	NA	-0.8	33.85
CY1998					
All services	2.2	NA	NA	NA	36.69*

Source: Compilation of conversion factors reported in *Federal Register,* 1991-1997.

***** The CY1998 conversion factor is the weighted average update which would have occurred in the absence of BBA97, applied to the primary care conversion factor. This amount is subject to a budget neutrality adjustment.

Other 1998 Payment Changes

Fee Schedule Changes

Annual Revisions. The work relative value units incorporated in the initial fee schedule were developed after extensive input from the physician community. Refinements in existing values and establishment of values for new services have been included in the annual fee schedule updates. This refinement and update process is based in part on recommendations made by the American Medical Association/Specialty Society Relative Value Update Committee (RUC) which receives input from 65 specialty societies. The law requires a review every 5 years. The 1997 fee schedule update reflected the results of the first 5-year review. The annual refinement process must be budget neutral.

1998 Changes. On October 31, 1997, the final fee schedule regulations for 1998 were published in the *Federal Register*.[3] This regulation includes modifications and adjustments to some of the 1997 relative value units. The following are some of the key changes:

- *Increase in Relative Value Units for Global Surgical Services.* Medicare bundles payments for services associated with a surgery into a global surgical code; the bundled payment includes payments for certain pre-operative and post-operative services. The regulation provides for an increase in the work relative value units for certain surgical services paid under a global fee. This increase reflects the general 1997 increase in payments for evaluation and management services.

- *Physician Supervision of Diagnostic Tests.* Beginning January 1, 1998, payments for diagnostic procedures payable under the fee schedule must be furnished under a specified level of physician supervision. All of these tests must be performed under at least a "general" level of physician supervision, except for certain procedures personally performed by independent qualified psychologists, clinical psychologists, qualified audiologists, and physical therapists who are qualified as electrophysiologic clinical specialists. Some tests, which are specified in the regulation, require either "direct" or "personal" supervision.

  Under *general supervision*, the physician retains the continuing responsibility for the training of the non-physician personnel who perform the diagnostic procedure and the maintenance of the necessary equipment and supplies. *Direct supervision* requires the physician to be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure. *Personal attendance* means a physician must be attendance in the room during the performance of the procedure.

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[3] *Federal Register*, v.62, no.211, October 31, 1997. p.59048-59260.

- *Geographic Adjustments*. The law requires that the geographic adjustments for the work, practice expense, and malpractice expense components be updated at least every 3 years with changes generally phased-in over 2 years. The current adjustment will be made in 1998 and 1999. HCFA reports that the revised geographic practice cost indices will have a negligible impact on physician payments in 1998. Payments will change by less than 0.5% in 75 of the 89 payment localities, with changes greater than 1% in only 2 localities (Rhode Island and Ventura, California).

- *Practice Expense Relative Values*. BBA 97 delayed implementation of a resource-based methodology for the determination of practice expenses. In 1998, there is an adjustment in practice expense values for certain services. Implementation of the resource-based practice expense methodology begins in 1999 and will be phased in over the 1999-2002 period. (See *Issues* section for a discussion of this item.)

2000 Change—Medical Malpractice Values. The malpractice component of the fee schedule currently uses historical charge data. BBA 97 directs HCFA to develop and implement a resource-based methodology for the malpractice expense component by January 1, 2000. A resource-based methodology would link this component to risk groups and relative insurance premiums across insurers

Documentation for Evaluation and Management Services

Approximately 30% of Medicare payments for physician services are for services which are classified as evaluation and management services (i.e., physician visits). There are several levels of evaluation and management codes. There is a concern that physicians have not been coding services uniformly nationwide. Efforts to verify that the correct level of care is billed is frequently hampered by the absence of appropriate documentation. This was highlighted in a July 1997 financial audit report from the Office of the Inspector General which stated that 47% of $23 billion in questionable Medicare payments was due to documentation problems.

Initial evaluation and management guidelines were issued in 1995. Subsequently, HCFA worked with the American Medical Association (AMA) to develop a new set of documentation guidelines. These guidelines were first released in May 1997 and subsequently revised in November 1997. The guidelines detail for the first time specific medical documentation requirements for single-organ system examinations and include slightly stricter clinical standards for multisystem exams. Medical record documentation is considered an important element contributing to high quality patient care. An appropriately documented record will assist Medicare in validating the site of service, medical necessity and appropriateness of the service, and that services were accurately reported. Use of medical documentation guidelines is expected to assist physicians who are audited by carriers and may serve, if necessary, as a legal document to verify the care provided.

The documentation guidelines were slated to be implemented on January 1, 1998. However, HCFA recently announced a 6-month implementation delay. Many physicians have criticized the guidelines as overly prescriptive and burdensome. In December 1997, the AMA House of Delegates adopted a policy which called on the

AMA to " take corrective action regarding the excessive content of the evaluation and management guidelines in cooperation with the national medical specialty societies."[4]

The documentation issue is expected to be the focus of continued attention in 1998. HCFA has indicated that it intends to instruct carriers to conduct *prepayment* reviews of some evaluation and management billings in 1998. The review will be based on the documentation provided.

Participation Agreements

Physicians who wish to become participating physicians are generally required to sign a participation agreement prior to January 1 of the year involved. The agreement is automatically renewed each year unless the physician notifies the Medicare carrier (i.e., the entity processing claims) that he or she wishes to terminate the agreement for the forthcoming year. Because of the large number of changes made by BBA 97, HCFA has delayed the 1998 enrollment deadline until February 1, 1998.

Private Contracts

Private contracting is the term used to describe situations where a physician and a patient agree not to submit a claim for a service *which would otherwise be covered and paid for by Medicare*. Under private contracting, physicians could bill patients at their discretion without being subject to upper limits specified by Medicare. HCFA had interpreted Medicare law to preclude such private contracts. BBA 97 included language permitting a limited opportunity for private contracting, effective January 1, 1998. However, if and when a physician decides to enter a private contract with a Medicare patient, that physician must agree to forego any reimbursement by Medicare for 2 years. The patient is not subject to the 2-year limit; the patient would continue to be able to see other physicians who were not private contracting physicians and have Medicare pay for the services. (This provision has proved quite controversial. For a discussion of the issue, see CRS Report 97-944, *Medicare: Private Contracts*.)

HCFA included in its 1998 Fact Sheet (which is forwarded by carriers to physicians as part of the participation enrollment process) an explanation of the provision and its implementation. The following were the major items addressed:

- *Physicians and Practitioners*. The private contract may be entered into by a physician or practitioner. Physicians are only doctors of medicine and osteopathy. (Not included are chiropractors, podiatrists, dentists, and optometrists.) Practitioners are physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse midwives, clinical psychologists, and clinical social workers.

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[4]Mahood, William. *Proposed Evaluation and Management Guidelines*. AMA Statement to the Practicing Physicians Advisory Council (PPAC), December 15, 1997.

- *Interaction with Participation Agreements*. A physician or practitioner must terminate a participation agreement at the end of a calendar year before he or she can opt out of Medicare the next year. Thus, a physician who enters into or rolls over a current participation agreement during the enrollment period for 1998 could not exercise the private contracting option during 1998. (HCFA is examining whether it would be administratively feasible to permit physicians and practitioners to exercise the option to opt out at times other than during the annual participation enrollment period. This decision will be made before the close of the 1998 enrollment period (February 2, 1998).)

- *Reassignment of Benefits*. If an organization that participates in Medicare bills on behalf of physicians, the physicians can not opt out because they are bound by the participation agreement of the entity that bills for their services. In order to opt out, the entity would have to terminate its participation agreement or the physician or practitioner must terminate the reassignment of benefits to the organization.

- *Effect on Non-Covered Services*. A private contract is unnecessary and private contracting rules do not apply for non-covered services. Examples of non-covered services include cosmetic surgery, routine physical exams, and preventive screening benefits furnished more frequently than a specified number of times during the year (for example, screening mammograms more frequently than annually).

- *Services Physician Anticipates Will Not Be Covered*. A physician or practitioner may furnish a service that Medicare will cover under some circumstances, but which the physician anticipates would not be deemed "reasonable and necessary" by Medicare in the particular case (e.g., multiple nursing home visits). If the beneficiary receives an "Advance Beneficiary Notice" that the service may not be covered, a private contract is not necessary to bill the patient if the claim is subsequently denied by Medicare.

- *Ordered Services*. Medicare will pay for services ordered by a physician who has opted out if: (a) the ordering physician has a unique provider identification number (UPIN) from Medicare; and (b) the services are provided by a physician or practitioner who has not opted out.

- *Emergency Services*. In an emergency or urgent care situation, a physician or practitioner who has opted out may treat a Medicare beneficiary with whom the physician does not have a private contract. The physician would be bound by the program's limitations on balance billing.

- *Medical Savings Accounts*. Physicians who provide services to beneficiaries enrolled in the medical savings account demonstration authorized under BBA 97 would not be required to enter into private contracts for those beneficiaries.

- *Group Practice*. An individual member of a group practice could opt out without affecting the status of other members of the group.

- *Contract Terms*. The contract between a physician and a patient must: (a) be in writing and be signed by the beneficiary or the beneficiary's legal representative in advance of the first service furnished under the arrangement; (b) indicate if the physician or practitioner has been excluded from participation from Medicare under the sanctions provisions; (c) indicate that by signing the contract the beneficiary agrees not to submit a Medicare claim; acknowledges that Medigap plans do not, and that other supplemental insurance plans may choose not to, make payment for services furnished under the contract; agrees to be responsible for payments for services; acknowledges that no Medicare reimbursement will be provided; and acknowledges that the physician or practitioner is not limited in the amount he or she can bill for services. A contract cannot be signed when the beneficiary is facing an emergency or urgent health care situation.

- *Affidavit*. A physician entering into a private contract with a beneficiary must file an affidavit with the Medicare carrier within 10 days after the first contract is entered into. The affidavit must: (a) provide that the physician or practitioner will not submit any claim to Medicare for 2 years; (b) provide that the physician or practitioner will not receive any Medicare payment for any services provided to Medicare beneficiaries either directly or on a capitated basis; (c) identify the physician or practitioner (so that the carrier will not make inappropriate payments during the opt out period); (d) be filed with all carriers who have jurisdiction over claims which would otherwise be filed with Medicare; and (e) be in writing and be signed by the practitioner.

Issues

Practice Expenses

The relative value for a service is the sum of three components: physician work, practice expenses, and malpractice expenses. While the calculation of work relative value units is based on resource costs, the calculation of practice expense costs (and malpractice costs) has been based on historical charges. A resource-based methodology for practice expenses would be tied to both direct practice expense costs (such as clinical personnel time and medical supplies used to provide a specific service to an individual patient) and indirect costs (such as rent, utilities, and business costs associated with maintaining a physician practice).

A number of observers have felt that the use of historical charges provides an inaccurate measure of actual resources used. A PPRC analysis suggested that practice expense relative value units for a service were most likely to be overvalued when they exceeded the work relative value units for the same service by a substantial amount. The Social Security Act Amendments of 1994 (P.L. 103-432) required the Secretary to develop a methodology for a resource-based system which would be implemented in calendar year 1998. HCFA developed a proposed methodology which was published as proposed rule-making June 18,1997; this methodology proved quite controversial. A number of observers suggested that sufficient accurate data had not been collected. They also cited the potential large scale payment reductions that might result for some physician specialties, particularly surgical specialties. PPRC estimated that under the proposed rule, payment rates for primary care would increase by 21.2%, and decrease by 18.4% for surgical services and 5.4% for other services.

BBA 97 delays implementation of a resource-based practice expense methodology for a year, until 1999 and provides for a 4-year transition. During 1998, the law makes provision for interim payment adjustments and requires development of new relative values. Specifically, in 1998, practice expense relative value units are reduced to 110% of work relative value for many services. Excluded from the reduction are services provided at least 75% of the time in an office setting or services which were slated to receive an increase in practice expense values under the June 1997 proposed rules. The amount of the reduction would be added to the relative value units of office visit codes. The law limited the amount of the reallocation to $390 million. HCFA estimates that the reallocation will be $330 million.

During 1998, HCFA will develop new relative values for practice expenses. The law requires the General Accounting Office (GAO) to review and report to Congress by February 7, 1998 on the June 1997 proposed rule. By March 1, 1998, HCFA is required to report on an explanation of the data and the methodology which will be used in the new rule. To the maximum extent practicable, the Secretary is required to utilize generally accepted accounting principles. The Secretary is also required to use actual data on equipment, utilization, and other assumptions (such as useful life of equipment or direct and indirect costs). Proposed regulations are to be published by May 1, 1998. On October 31, 1997, HCFA published a notice in the

Federal Register requesting input on these issues from physicians and other interested parties.

The new resource-based system will be phased-in beginning in calendar year 1999. In that year, 75% of the payment will be based on the 1998 charge-based relative value unit and 25% on the resource-based relative value. In 2000, the percentages will be 50% charge-based and 50% resource-based. For 2001, the percentages will be 25% charge-based and 75% resource-based. Beginning in 2002, the values will be totally resource-based.

Level of Expenditures

In FY1997, payments made under the physician fee schedule to physicians and nonphysician practitioners totalled $30.7 billion, or approximately 14.8% of total Medicare benefit payments. The level of total Medicare spending has been of concern to policymakers for a number of years. Because of its rapid growth, both in terms of aggregate dollars and as a share of the federal budget, the program has been a major focus of deficit reduction legislation passed by the Congress since 1980. With few exceptions, reductions in program spending have been achieved largely through reductions in payments to providers, primarily hospitals and physicians. The most recent law, BBA 97, includes net savings in payments to physicians and other practitioners of $4.5 billion over the FY1998-FY2002 period and $7.9 billion over the FY1998-FY2007 period. This represents 3.9% of total Medicare savings ($116.4 billion) over the initial 5-year period and 2.0% of total Medicare savings ($393.8 billion) over the 10-year period.

A number of physician groups have expressed concern over the impact of recent budget reconciliation bills. They point to the fact that even prior to enactment of BBA 97, the Congressional Budget Office (CBO) estimated that the conversion factors would decline over the 10-year projection period, though overall payments under the fee schedule would increase. Following enactment of BBA 97, the year-to-year adjustments are expected to be further constrained. The impact will not, however, be felt equally across all physician groups. Both the move to a single conversion factor and the changes in the calculation of practice expenses will have the greatest impact on payments for surgical services. For example, the 1998 conversion factor is 10.4% lower than the 1997 conversion factor for surgical services, and 8.4% lower for non-surgical non-primary care services; conversely it is 2.6% higher for primary care services. However, total Medicare payments reflect changes in all components of the physician fee schedule as well as the volume and mix of services provided. **Table 2** shows HCFA's estimate for 1998 by specialty of the net impact on physician payments of BBA 97 provisions; it should be noted that the practice expense column only reflects the reallocation applicable in 1998, not the move toward resource-based practice expenses which will be phased-in beginning in 1999; this action is expected to further reduce payments for surgical services.

Access. Some observers have suggested that as Medicare places additional constraints on spending, access to care may be impeded. To date, this has not been the case. Analyses by both PPRC and HCFA of the impact of the fee schedule shows that access to care has continued to remain good for most beneficiaries. However, vulnerable populations (such as Nonwhites and Hispanics, persons with no

supplemental insurance, and the functionally disabled) who had trouble obtaining care prior to implementation of the fee schedule continued to exhibit lower utilization and worse health outcomes.

Comparison to Private Rates. The Medicare program is not alone in attempting to constrain cost increases. Private insurers and employers are also attempting to control spending through various approaches including an increased emphasis on managed care. In 1996, PPRC estimated that while the gap between Medicare payments and payments by private payers widened over the 1989-1992 period, it lessened in subsequent years; this reflected both higher Medicare payment updates and lower rates of increase in private rates. PPRC estimated that the ratio of Medicare rates to private payer rates was 0.71 in 1989, dropping to a low of 0.61 in 1992, and rising to 0.66 in 1994; PPRC projected that the ratio would increase to 0.71 in 1996.

Table 2. 1998 Percent Change in Payments by Specialty*

Specialty	Change due to single conversion factor	Change due to relative value units			Combined change
		Work	Practice expense	Total	
M.D./D.O. Physicians:					
Radiation Oncology	9.2	-0.7	-0.7	-0.7	8.4
Psychiatry	9.0	-0.9	-0.4	-0.7	8.2
Radiology	9.0	-0.9	0.6	-0.7	8.2
Pathology	9.3	-0.8	-1.5	-1.1	8.1
Hematology/Oncology	7.1	-0.6	2.5	0.8	8.0
Neurology	7.9	0.7	1.2	0.0	7.9
Pulmonary	8.1	-0.8	0.4	-0.4	7.7
Rheumatology	5.7	-0.9	5.0	1.4	7.2
Gastroenterology	8.5	-0.8	-2.0	-1.3	7.1
Internal medicine	6.4	-0.9	3.0	0.6	7.0
Family practice	5.0	-1.0	5.3	1.3	6.4
Cardiology	7.9	-0.6	-2.3	-1.4	6.4
Other physician	6.4	-0.6	0.5	-0.2	6.2
General practice	4.7	-0.4	4.1	1.2	6.0
Nephrology	6.0	-0.8	-1.9	-1.2	4.7
Clinics	4.5	-0.3	0.2	-0.1	4.4
Emergency medicine	3.8	-0.7	-0.5	-0.6	3.2
Anesthesiology	1.2	1.0	0.7	0.9	2.1
Obstetrics/Gynecology	-2.3	2.8	3.9	3.0	0.6
Otolaryngology	-0.1	0.3	1.1	0.6	0.5
General surgery	-4.0	3.8	-0.4	1.8	-2.3
Vascular surgery	-4.0	4.3	0.7	1.5	-2.6
Urology	-3.3	0.6	0.3	0.4	-2.9
Orthopedic surgery	-4.8	4.0	-2.0	0.8	-4.0
Dermatology	-4.8	-0.6	1.7	0.2	-4.6

Plastic surgery	-6.9	3.9	-0.6	1.7	-5.3
Ophthalmology	-3.3	1.6	-6.8	-2.6	-5.8
Neurosurgery	-5.7	3.2	-3.6	-0.2	-5.9
Thoracic surgery	-7.0	5.0	-4.7	-0.2	-7.2
Cardiac surgery	-8.1	5.4	-5.9	-0.7	-8.8
Others:					
Chiropractic	9.3	-0.8	-0.8	-0.8	8.4
Suppliers	9.3	-0.8	-1.1	-1.0	8.2
Optometry	5.7	-0.9	1.8	0.1	5.8
Nonphysician practitioners	5.1	0.3	-2.2	-0.6	4.5
Podiatry	-5.2	0.5	1.4	0.8	-4.4

Source: *Federal Register*, v. 62, no. 211, Oct. 31, 1997. p. 59097, 59262.

* Table reflects changes from 1997 payments due to the relative value units and single conversion factor, excluding the 0.3% volume and intensity increase associated with the single conversion factor and the 0.1% volume and intensity increase associated with the relative value unit changes.