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Report for Congress

Medicare: Payments to Physicians

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Medicare: Payments to Physicians

Summary

Medicare law specifies a formula for calculating the annual update in payments for physicians services. The formula resulted in an actual negative update in payments per service for 2002. An additional reduction was slated to go into effect in 2003, but was prevented by recent congressional action. Many Members were concerned about reports that some doctors had stopped seeing new Medicare patients in response to payment reductions.

Medicare payments for services of physicians and certain non-physician practitioners are made on the basis of a fee schedule. The fee schedule, in place since 1992, is intended to relate payments for a given service to the actual resources used in providing that service. Payments under the fee schedule were estimated at $42.8 billion in 2002 (17% of total benefit payments). The fee schedule assigns relative values to services which 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 in costs. The adjusted relative values are then converted into a dollar payment amount by a conversion factor. The conversion factor for 2001 was $38.2581. The conversion factor for 2002 dropped 5.4% to $36.1992. Recent congressional action prevented an additional 4.4% cut on March 1, 2003.

The law provides a specific formula for calculating the annual update to the conversion factor. The intent of the formula is to place a restraint on overall increases in spending for physicians' services. Several factors enter into the calculation of the formula. These include: (1) the Medicare economic index (MEI), which measures inflation in the inputs needed to produce physicians' services; (2) the sustainable growth rate (SGR), which is essentially a target for Medicare spending growth for physicians' services; and (3) an adjustment that modifies the update, which would otherwise be allowed by the MEI, to bring spending in line with the SGR target. The SGR target is not a limit on expenditures. Rather, the fee schedule update reflects the success or failure in meeting the target. If expenditures exceed the target, the update for a future year is reduced. This is what occurred for 2002. It was also slated to occur in 2003.

The Administration had stated that if it were allowed to go back and update the data used in calculations of the formula for previous years (which was not allowed under prior law) the update for 2003 would be 1.6%. On February 20, 2003, the President signed into law the Consolidated Appropriations Resolution of 2003 (P.L. 108-7). This law permitted redeterminations of the SGR for prior years. These redeterminations were included in the final regulation published on February 28, 2003. That regulation also set the 2003 conversion factor at $36.7856, a 1.6% increase over the 2002 level. P.L.108-7 did not, however, address the underlying issues related to application of the formula for the annual payment update. It is possible that the Congress may look at this issue later this year as part of the overall discussion on Medicare reform issues. This report will be updated to reflect any legislative action.

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Introduction: Medicare Fee Schedule

Medicare is a nationwide program which offers health insurance protection for 40 million aged and disabled persons. Currently, 86% of beneficiaries obtain covered services through the "original Medicare" program (also referred to as "fee-for-service Medicare"). Under this program, beneficiaries obtain services through providers of their choice and Medicare makes payments for each service rendered (i.e., fee-for-service) or for each episode of care. Approximately 14% of beneficiaries are enrolled in managed care organizations under the Medicare+Choice program. These entities assume the risk for providing all covered services in return for a fixed monthly per capita payment.

Medicare law and regulations contain very detailed rules governing payments to physicians and other providers under the fee-for-service system. Payments for physicians services under fee-for-service Medicare are made on the basis of a fee schedule. The fee schedule also applies to services provided by certain nonphysician practitioners such as physician assistants and nurse practitioners as well as the limited number of Medicare-covered services provided by limited licensed practitioners (chiropractors, podiatrists, and optometrists). Payments under the fee schedule are estimated at $40.4 billion in 2001 and $42.8 billion in 2002 (over one-sixth of total Medicare benefit payments).[1]

Why Fee Schedule Was Enacted

The 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 reasonable charge 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.

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[1] Congressional Budget Office. March 2002 Baseline.

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. 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.

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 of the approximately 7,500 physician service codes 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:

- *Physician work component*, which measures physician time, skill, and intensity in providing a service;
- *Practice expense component*, which measures average practice expenses such as office rents and employee wages (which, for certain services can vary depending on whether the service is performed in a facility, such as an ambulatory surgical facility, or in a non-facility setting); and
- *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.[2, 3] These are added together to produce an indexed relative value unit for the service for the locality. There are 92 service localities nationwide.

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.[4]

The 2001 conversion factor was $38.2581. Thus, the payment for a service with an adjusted relative value of 2.3 was $87.99.[5] Anesthesiologists are paid under a separate fee schedule which uses base and time units; a separate conversion factor ($17.83 in 2001) applies.

The 2002 conversion factor was $36.1992 ($16.60 for anesthesiology services). The 2003 conversion factor is $36.7856 ($17.05 for anesthesiology services). The new conversion factor is effective for services provided on or after March 1, 2003. (See *Calculation of Annual Update to the Fee Schedule* section for a discussion of the decrease from 2001 to 2002 and the increase from 2002 to 2003.)

Bonus Payments. The law specifies that physicians who provide covered services in any rural or urban health professional shortage area (HPSA) are entitled to an incentive payment. This is a 10% bonus over the amount which would otherwise be paid under the fee schedule. The bonus is only paid if the services are actually provided in the HPSA, as designated under the Public Health Service Act.

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[2] The geographic adjustments are indexes that reflect cost differences among areas compared to the national average in a "market basket" of goods. The work adjustment is based on a sample of median hourly earnings of workers in six professional specialty occupation categories. The practice expense adjustment is based on employee wages, office rents, medical equipment and supplies, and other miscellaneous expenses. The malpractice adjustment reflects malpractice insurance costs. The law specifies that the practice expense and malpractice indices reflect the full relative differences. However, the work index must reflect only *one-quarter* of the difference. Using only one-quarter of the difference generally means that rural and small urban areas would receive higher payments and large urban areas lower payments than if the full difference were used.

[3] For a detailed description of how the geographic adjustments are calculated, see the Appendix.

[4] Initially there was one conversion factor. By 1997, there were three factors: one for surgical services; one for primary care services; and one for all other services. The Balanced Budget Act of 1997 (BBA 97) provided for the use of a single conversion factor beginning in 1998.

[5] The law requires that changes to the relative value units under the fee schedule can not cause expenditures to increase or decrease by more than $20 million from the amount of expenditures that would have otherwise been made. This "budget neutrality" requirement is implemented through an adjustment to the conversion factor

Publication of Fee Schedule. Medicare is administered by the Centers for Medicare and Medicaid Services (CMS).[6] Each fall, CMS publishes in the *Federal Register* the relative values and conversion factor that will apply for the following calendar year. Updates to the geographic adjustment are published at least every 3 years.

The fee schedule is generally published by November 1 and is effective January 1. Due to some technical glitches, the 2003 fee schedule was not published until December 31, 2002. It was slated to become effective March 1, 2003. On February 20, 2003 the President signed into law the Consolidated Appropriations Resolution of 2003 (P.L.108-7). This law provided for a recalculation of the formula used in determining the annual payment update. On February 28, 2003, a new regulation was issued which contained a new update for 2003 and replaced the update provisions of the December regulation. The other provisions in the December rule continue to apply. All provisions are effective March 1, 2003.

Beneficiary Protections

Medicare pays 80% of the fee schedule amount for physicians' services after beneficiaries have met the $100 annual Part B deductible. Beneficiaries are responsible for the remaining 20%, known as coinsurance. A physician may choose whether or not to accept **assignment** on a claim.[7] 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 on *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**. It should be noted that the term "nonparticipating physician" does not mean that the physician doesn't deal with Medicare. Nonparticipating physicians still treat Medicare patients and receive Medicare payments for providing covered services.

There are a number of incentives for physicians to participate, chief of which is that the fee schedule payment amount for nonparticipating physicians is only 95% of the recognized amount for participating physicians, regardless of whether they accept assignment for the particular service or not.

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

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[6] Prior to June 14, 2001, this agency was known as the Health Care Financing Administration (HCFA).

[7] Nonphysician practitioners (such as nurse practitioners and physician assistants) paid under the fee schedule are required to accept assignment on all claims. These practitioners are different from limited licensed practitioners (such as podiatrists and chiropractors)who have the option of whether or not to accept assignment.

physicians (which is only 9.25% higher than the amount recognized for participating physicians i.e., 115% x .95 = 1.0925). (See **Table 1)**

As of January 2002, 89.7% of physicians (and limited licensed practitioners) billing Medicare were participating physicians. Close to 98% of Medicare claims were assigned.[8]

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.

Due to the delay in issuing the 2003 fee schedule, the participation enrollment period for 2003 runs until April 14, 2003.

Submission of Claims

Physicians and practitioners are required to submit all claims for *covered* services to Medicare carriers. These claims must be submitted within 1 year of the service date. An exception is permitted if a beneficiary requests that the claim not be submitted. This situation is most likely to occur when a beneficiary does not want to disclose sensitive information (for example, treatment for mental illness or AIDS). In these cases, the physician may not bill more than the limiting charge. The beneficiary is fully liable for the bill. If the beneficiary subsequently requests that the claim be submitted to Medicare, the physician must comply. Such exceptions should occur in only a very limited number of cases.

A physician or practitioner may furnish a service that Medicare may cover under some circumstances but which the physician or practitioner anticipates would not be covered in the particular case (for example, multiple nursing home visits). In this case, the physician or practitioner should give the beneficiary an *"Advance Beneficiary Notice" (ABN)* that the service may not be covered. If the claim is subsequently denied by Medicare, there are no limits on what may be charged for the service. If, however, the physician or practitioner does not give the beneficiary an ABN, and the claim is denied because the service does not meet coverage criteria, the physician cannot bill the patient. (See **Table 2**.)

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[8] Department of Health and Human Services, Centers for Medicare and Medicaid Services. *2001 Data Compendium.* September 2001.

Table 1. Medicare and Physicians

Type of physician and claim	Medicare pays	Beneficiary pays	Balance billing charges
Participating physician — Must take ALL claims on assignment during the calendar year. (Signs a participation agreement)	80% of fee schedule amount	20% of fee schedule amount (plus any unmet deductible)	None permitted
Nonparticipating physician — May take or not take assignment on a claim-by-claim basis			
(A) Takes **assignment** on a claim	80% of fee schedule amount (recognized fee schedule amount = 95% of recognized amount for participating physicians)	20% of fee schedule amount recognized for nonparticipating physicians (plus any unmet deductible)	None permitted
(B) Does not take assignment on a claim	80% of fee schedule amount (recognized fee schedule amount = 95% of recognized amount for participating physicians)	(a) 20% of fee schedule amount recognized for nonparticipating physicians (plus any unmet deductible); plus (b) any balance billing charges.	Total bill cannot exceed 115% of recognized fee schedule amount (actually 109.25% of amount recognized for participating physicians, i.e., 115% x 95%)

Table 2. Billing Provisions Applicable to Claims Denied by Medicare

Claim submission to Medicare	Claim denied	Billing limits on denied claim
Claim submitted without advance beneficiary notice (ABN) Physician submits claim according to billing rules for assigned or unassigned claims, as appropriate.	(A) Denied because the service is categorically not covered (e.g., hearing aids)	No limits on amounts physician can charge.
	(B) Denied because service does not meet coverage criteria.	Physician cannot bill beneficiary and must refund any amounts beneficiary may have paid.*

Claim submission to Medicare	Claim denied	Billing limits on denied claim
Claim submitted with advance beneficiary notice (ABN) Physician submits claim according to billing rules for assigned or unassigned claims, as appropriate.	(A) Denied because the service is categorically not covered. (e.g., hearing aids)	No limits on amounts physician can charge.
	(B) Denied because service does not meet coverage criteria.	No limits on amounts physician can charge.

* If Medicare pays under a "waiver of liability" because the physician had no reason to know claim would not be paid, regular billing rules apply.

There is another condition under which physicians and practitioners do not submit claims for services which would otherwise be covered by Medicare. This occurs if the physician or practitioner is under a private contacting arrangement (See discussion under *Other Issues*, below.) In this case, physicians are precluded from billing Medicare or receiving any payment from Medicare for 2 years.

Refinements in Relative Value Units

On average, the work component represents 54.5% of a service's relative value, the practice expense component represents 42.3%, and the malpractice component represents 3.2%.[9] The law provides for refinements in relative value units.

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's Specialty Society Relative Value Update Committee (RUC) which receives input from 100 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 2002 fee schedule reflected the results of the second 5-year review.

While the calculation of work relative value units has always been based on resources used in providing a service, the values for the practice expense components and malpractice expense components were initially based on historical charges. The Social Security Amendments of 1994 (P.L. 103-432) required the Secretary to develop a methodology for a resource-based system for practice expenses which would be implemented in 1998. Subsequently, the Secretary developed a system. BBA 97 delayed its implementation. It provided for a limited adjustment in practice expense values for certain services in 1998. It further provided for implementation

[9] Medicare Payment Advisory Commission. *Report to the Congress: Medicare Payment Policy*. March 2001.

of a new resource-based methodology to be phased-in beginning in 1999. The system would be fully phased in by 2002. (See *Other Issues* section for a discussion of this item.)

BBA 97 also directed HCFA (now CMS) to develop and implement a resource-based methodology for the malpractice expense component. HCFA developed the methodology based on malpractice premium data. Malpractice premiums were used because they represent actual expenses to physicians and are widely available. The system was incorporated into the fee schedule beginning in 2000.

Calculation of Annual Update to the Fee Schedule

As noted, 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 the same for all services. It is updated each year according to a complicated formula specified in law. The intent of the formula is to place a restraint on overall spending for physicians' services. Several factors enter into the calculation of the formula. These include: 1) the sustainable growth rate (SGR) which is essentially a target for Medicare spending growth; 2) the Medicare economic index (MEI) which measures inflation in the inputs needed to produce physicians services; and 3) the update adjustment factor which modifies the update, which would otherwise be allowed by the MEI, to bring spending in line with the SGR target.

The SGR system was established because of the concern that the fee schedule itself would not adequately constrain increases in spending for physicians' services. While the fee schedule specifies a limit on payments per service, it does not place a limit on the volume or mix of services. The use of SGR targets is intended to serve as a restraint on aggregate spending. The SGR targets are not limits on expenditures. Rather the fee schedule update reflects the success or failure in meeting the target. If expenditures exceed the target, the update for a future year is reduced. If expenditures are less than the target, the update is increased.

This section provides an overview of how the update percentage is calculated, shows the calculation for 2002 and 2003, and discusses some of the issues raised by the statutory formula.

General Rules

The annual percentage update to the conversion factor, equals the MEI, subject to an adjustment (known as the update adjustment factor) to match target spending for physicians services under the SGR system.[10]

Update Adjustment Factor. The update adjustment sets the conversion factor at a level so that projected spending for the year will meet allowed spending

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[10] During a transition period (2001-2005), an additional adjustment is made to achieve budget neutrality. The adjustment is: -0.2% for the first 4 years and + 0.8% in the last year.

by the end of the year. Allowed spending for the year is calculated using the SGR. However, in no case can the update adjustment factor be less than minus 7% or more than plus 3%.

The technical calculation of the adjustment factor has changed several times. Beginning in 2001, the update adjustment factor is the sum of: (1) the *prior year adjustment component*, and (2) the *cumulative adjustment component*. The prior year adjustment component is determined by: (1) computing the difference between allowed expenditures for physicians' services for the prior year and the amount of actual expenditures for that year; (2) dividing this amount by the actual expenditures for that year; and (3) multiplying that amount by 0.75. The cumulative adjustment component is determined by: (1) computing the difference between allowed expenditures for physicians' services from April 1, 1996 through the end of the prior year and the amount of actual expenditures during such period; (2) dividing that difference by actual expenditures for the prior year as increased by the SGR for the year for which the update adjustment factor is to be determined; and (3) multiplying that amount by 0.33. Use of both the prior year adjustment component and the cumulative adjustment component allows any deviation between cumulative actual expenditures and cumulative allowed expenditures to be corrected over several years rather than a single year.

Sustainable Growth Rate. The law specifies a formula for calculating the SGR. It is based on changes in four factors: (1) estimated changes in fees; (2) estimated change in the average number of Part B enrollees (excluding Medicare+Choice beneficiaries); (3) estimated projected growth in real gross domestic product (GDP) growth per capita; and (4) estimated change in expenditures due to changes in law or regulations.

Calculation Periods; Revisions. Since the implementation of the fee schedule in 1992, the update to the conversion factor has been linked to an expenditure target mechanism. Initially this was the Medicare Volume Performance Standard or MVPS. Beginning in 1999, the SGR mechanism has been used. The calculations of both the SGR and the update adjustment factor were revised by the Balanced Budget and Refinement Act of 1999 (BBRA 99).

Prior to BBRA, data for various measurement periods were used for the calculation of the SGR and the update adjustment factor. BBRA provided that after a transition period (which used both fiscal years (FY) and calendar years (CY)) all calculations are to be made on a calendar year basis. The legislation also provided that any deviation between cumulative actual expenditures and cumulative allowed expenditures are corrected over several years rather than in a single year, thus resulting in less year-to-year volatility in the fee schedule update. Further, the law provided for two updates to allowed expenditures and actual expenditures to reflect more recent data. Any revisions that result from the revision in the estimates would be reflected in the adjustment factor for the following year.

By November 1 of each year, (using the best data available as of September 1), CMS is required to publish in the *Federal Register*, the SGRs for three time periods. These periods are the upcoming year, the current year, and the preceding year. Thus the SGR is estimated and revised twice, based on later data. There are no further

revisions to the SGR once it has been estimated and subsequently revised in each of the 2 years following the initial estimates. For example, by November 1, 2001, CMS was required to revise the SGRs for FY2000 and CY2000[11] and CY2001 and to establish the SGR for CY2002 based on the best available data as of September 1, 2001. There can be no further revisions to the FY2000 and CY2000 data after this time.

By November 1, 2002, CMS was to publish an estimate of the SGR for CY2003, a revision of the CY2002 SGR estimated in 2001 and a revision of the CY2001 SGR first estimated 2 years earlier and revised 1 year earlier. Publication of these amounts was first delayed until December 31, 2002. These amounts were subsequently revised as a result of the enactment of the Consolidated Appropriations Act of 2003 (P.L. 108-7) which allowed CMS to go back and use actual data to determine the SGRs for FY 1998 and FY1999 for the purposes of determining future fee schedule updates. Two factors in the SGR calculation accounted for the major differences between estimated and actual data. These were fee-for-service enrollment in Medicare (because fewer people than expected enrolled in managed care) and changes in the real per capita growth in the GDP. Changing the FY1998 and FY1999 numbers to reflect actual data had the effect of increasing the SGR used for the calculation of the 2003 update.

Calculation for 2002

Conversion Factor. On November 1, 2001, CMS announced the conversion factor update for 2002. The update was actually negative: -5.4% (compared to a 4.5% increase in 2001). Thus, the conversion factor for 2002 ($36.1992) is 5.4% less than the conversion factor for 2001 ($38.2581). While a negative update had been expected, the percentage reduction was somewhat larger than previously estimated. CMS noted that the formula for calculating the update is specified in law; it therefore did not have leeway to modify the update.

As noted above, the update reflects the MEI plus an adjustment to reflect the success or failure in meeting the SGR target. The update derived from these calculations resulted in an update of: -4.8%. In addition, certain required budget neutrality adjustments are made through adjustments to the conversion factor. Thus, the final update to the conversion factor is: -5.4%.

Update Adjustment. The MEI for 2002 was 2.6%. The update adjustment factor (after applying the formula described above) was 0.93 (i.e., -7.0%). The reduction would actually have been larger (based on the difference between allowed spending and actual spending); however, the maximum reduction allowed under the law is 7%. An additional statutory reduction (-0.2 %) applied in 2002. These three items taken together resulted in the -4.8% update. (**See Table 3**)

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[11] As noted, the calculation of the update adjustment factor is based on a calculation of allowed and actual expenditures. Allowed expenditures for the first 3 months of CY2000 use the FY2000 SGR; the remaining 9 months use the CY2000 SGR. Calendar years are used for all future calculation periods.

Additional Adjustments. In addition to the update calculation, the law requires that changes to relative value units can not cause expenditures to increase or decrease more than $20 million from the amount of expenditures that would otherwise have been made. CMS implements this requirement through a budget neutrality adjustment to the conversion factor. For 2002, two adjustments were made to meet this requirement. The first was a 0.46% reduction to account for the increase in the work relative values resulting from the 5-year review. The second was a 0.18% reduction to account for an anticipated increase in the volume and intensity of services in response to the final year of the implementation of resource-based practice expense relative value units.

Table 3. Calculation of the 2002 Conversion Factor

2001 Conversion factor	$38.2581
Multiply by *Update* (product of: MEI plus 1 (1.026), update adjustment factor (0.93), and additional statutory reduction (.998, i.e., a 0.2% reduction))	x 0.9523
Multiply by *Budget Neutrality Adjustment* for revision of relative value units as a result of 5-year review (.9954, i.e., a 0.46% reduction)	x 0.9954
Multiply by *Budget Neutrality Adjustment* for Practice Expense Transition (.9982, i.e., a 0.18% reduction)	x 0.9982
2002 Conversion factor	$36.1992

Sustainable Growth Rate. The negative update adjustment factor for 2002 reflected the application of the SGR system. This system is designed to adjust for how well actual expenditures meet SGR target expenditures. Three items had particular importance for the 2002 calculation. First, is the fact that allowed expenditures under the SGR system declined from earlier estimates in part because GDP growth was lower than anticipated. Second, claims data for physicians services in the first half of 2001 showed higher than expected spending over the period and raised estimates for all of 2001. Third, certain technical errors in the calculations for previous years (which raised the updates in those years) further reduced the 2002 update. These factors taken together mean that the reduction in the update adjustment factor, and by extension the conversion factor, were greater than previously estimated.

As required by law, the November 1, 2001 fee schedule regulation contained the initial estimate for the SGR for 2002 (5.6%), a revised estimate for the SGR for 2001 (6.1%), and final estimates for the SGRs for FY2000 (6.9%) and CY2000 (7.3%). As noted earlier, the law provided for two updates to allowed expenditures and actual expenditures to reflect more recent data. Any changes that result from the revision in the estimates are reflected in the adjustment factor for the following year. Thus, any changes for 2001 and 2002 are reflected in subsequent calculations.

Calculation For 2003

Conversion Factor. As noted, the law requires the fee schedule for the following year to be issued by November 1. However, due to technical complications, publication of the 2003 fee schedule was first delayed until December 31, 2002 and revised on February 28, 2003 in response to the enactment of the Consolidated Appropriations Resolution of 2003 (CAR). As a result of the delays, the 2003 fee schedule is effective March 1, 2003. The December regulation would have set the 2003 update at a negative 4.4%. As a result of the CAR provision, the update for 2003 is 1.6%.

Update Adjustment. The MEI for 2003 is 3.0%. The update adjustment factor (after applying the formula described above) is 0.989. An additional statutory reduction (-0.2 %) applies in 2003. An additional budget neutrality adjustment (-0.4) is made to account for the increase in work relative values for anesthesia services resulting from the 5-year review. (**See Table 4**)

Table 4. Calculation of the 2003 Conversion Factor

2002 Conversion factor	$36.1992
Multiply by *Update* (product of: MEI plus 1 (1.030), update adjustment factor (0.989), and additional statutory reduction (.998, i.e., a 0.2% reduction))	x 1.0166
Multiply by budget neutrality adjustment (- 0.4%) to account for increase in anesthesia work relative values	x 0.9996
2003 Conversion factor	$36.7856

Issues

The negative update for 2002 (as well as the possibility that the 2003 update would also have been negative) raised concerns for many observers. There is increasing concern that some physicians may be unwilling to accept new Medicare patients. As noted, the negative update is a direct result of the application of the SGR system. Some observers have suggested that this system should be replaced.

Background on SGR. As noted earlier, the fee schedule was included in OBRA 89 in order to respond to two major concerns with the then existing reasonable charge payment methodology. First, observers noted that payments for individual services under the reasonable charge methodology were not related to the actual resources used. Second, they noted that overall Medicare payments for physicians' services were rising at a rapid pace. The fee schedule itself responded to the first concern by beginning to relate payments for individual services to actual resources used. However, a number of observers suggested that physicians could potentially respond to the cuts in payments for individual services by increasing the overall volume of services. As a result, enactment of the fee schedule itself might not slow the overall growth rate in expenditures.

The Congress responded to this concern by establishing, in OBRA 89, an expenditure target mechanism known as the Medicare Volume Performance Standard (MVPS). Under the MVPS, an annual expenditure target for physicians' services was established. The use of the target was intended to serve as a restraint on aggregate Medicare spending for physicians' services. If expenditures fell below the target in a year, the increase to the conversion factor in a future year would be larger than the MEI. Conversely, if expenditures were above the target in a year, the increase to the conversion factor in a future year would be less than the MEI.

Several statutory changes to the MVPS and conversion factor calculation rules were included in subsequent budget reconciliation bills. Subsequently, the PPRC, among others, identified several methodological flaws with the revised MVPS system. The MVPS was replaced in 1999 by the SGR, in part based on PPRC recommendations. The SGR system is quite different from the MVPS. Under the MVPS system, a new MVPS was calculated each year, and a conversion factor update in a year was based on the success in meeting the target in a prior period. The key difference between the MVPS and the SGR system is that the SGR system looks at cumulative spending since April 1, 1996.

CMS states that the SGR system worked well for physicians for the first years it was in effect. For the period 1998-2001, the cumulative increase in the update was 15.9 % compared to a medical inflation increase of 9.3%.[12] However, beginning in 2002, the trend reversed.

Current Concerns. MedPAC, which replaced the PPRC, has reported that the SGR system continues to have methodological flaws. In 2001, it recommended that:

> ... the Congress replace the SGR system with an annual update based on factors influencing the unit costs of efficiently providing physician services. MedPac's recommendation would correct three problems. First, although the SGR system accounts for changes in input prices, it fails to account for other factors affecting the cost of providing physician services, such as scientific and technological advances and new federal regulations. Second, it is difficult to set an appropriate expenditure target with the SGR system because spending for physician services is influenced by many factors not explicitly addressed, including shifts of services among settings and the diffusion of technology. The SGR system attempts to sidestep this problem with an expenditure target based on growth in real GDP, but such a target helps ensure that spending is affordable without necessarily accounting for changes in beneficiaries' needs for care. Third, enforcing the expenditure target is problematic. An individual physician reducing volume in response to incentives provided by the SGR system would not receive a proportional increase in payments. Instead the increase would be distributed among all physicians providing services to Medicare beneficiaries.
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> These problems with the SGR system can have serious consequences. Updates under the SGR system will nearly always lead to payments that diverge from costs because actual spending is unlikely to be the same as the target. When this

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[12] Centers for Medicare and Medicaid Services (CMS). *CMS Announces Physician Pay Changes for 2002.* Press Release, October 31, 2001.

> occurs, payments will either be too low, potentially jeopardizing beneficiary access to care, or too high, making spending higher than necessary.[13]

MedPAC's March 2002 report specifically recommended repeal of the SGR system. It recommended requiring the Secretary to update payments for physicians services based on the estimated change in input prices for the coming year less an adjustment for savings attributable to increased productivity.(A so-called "multifactor productivity" factor would be used.) At the time, CBO estimated that making the changes recommended by MedPAC would cost $126 billion over 10 years.[14]

As noted, there was a further problem with the SGR system. When CMS issued its December 2002 regulation, it stated that is was unable, under the then existing law, to go back and revise previous estimates which were used in calculating the SGR for previous years. Errors in previous estimates meant that payment updates in some earlier years were higher than they should have been; in turn, this meant that spending was higher in those years than it would otherwise have been. Higher spending meant that updates in future periods were less in order to keep spending in line with the SGR target. As noted, the CAR, enacted February 20, 2003, enabled CMS to revise FY 1998 and FY 1999 numbers; thereby resulting in a positive, rather than a negative, update for 2003. However, this legislation did not address the underlying issues related to application of the formula for the annual payment update.

Legislation in the 107th Congress

On June 28, 2002, the House passed the Medicare Modernization and Prescription Drug Act of 2002 (H.R. 4954). This legislation included provisions relating to physician payments. While the bill did not incorporate a long-term modification to the sustainable growth rate system, it did modify the update calculation for 3 years. It specified that the update for 2003 would be 2%. In addition, the calculation for 2004 and 2005 would be modified, thereby making it less likely that physician spending would reach levels that would trigger reductions in the conversion factor. The legislation would have made the following changes:

- When calculating the update adjustment factor for 2004 and 2005, actual 2002 spending data would be used as the measure of allowable costs for 2002.
- Spending from January 1, 2002, rather than April 1, 1996 would be used as the beginning date for calculating the base period for the SGR calculation.
- The formula for calculating the sustainable growth rate would be modified. For 2003, 2004, and 2005, 1 percentage point would be added to the GDP factor.

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[13] Medicare Payment Advisory Commission. *Medicare in Rural America*. Report to Congress, June 2001.

[14] Congressional Budget Office. *Medicare's Payments to Physicians*, statement by Dan L. Crippen, before the House Committee on Ways and Means, Subcommittee on Health, February 28, 2002.

- A permanent change would be made in the computation of the GDP, beginning for 2002. The current factor which measures the 1-year change from the preceding year would be replaced with a factor that measures the annual average change over the preceding 10 years.

A similar provision was included in a measure (S. 3018) introduced by the Chairman and Ranking Member of the Senate Finance Committee (Senators Baucus and Grassley). The Committee did not hold a markup on the measure because Members were unable to come to agreement on the scope of a Medicare bill.

At the end of the session there was an attempt in the House to just address the physician payment issue. The House-passed H.R. 5063, the Armed Forces Tax Fairness Act of 2002. This bill included a provision which would have protected CMS from suits if it made redeterminations of SGRs for prior years. The bill would not have required such redeterminations. The Senate did not approve this provision. However, this was the approach subsequently included in the CAR, enacted February 20, 2003.

Despite the fact that most Members agreed that the physician payment issue should be addressed, the 107th Congress did not take final action. This was because the Congress was unable to come to agreement on the scope of a Medicare bill. Many Members, including Senators Grassley and Baucus, were unwilling to pass a bill that addressed only physician payment issues without also increasing payments for some other health care provider categories. Further, many Members expressed reluctance to pass any "give-back" measure without enacting a drug benefit for beneficiaries.

Legislation in the 108th Congress

On January 7, 2003, Congressman Thomas, Chairman of the House Ways and Means Committee, introduced a measure (H.J.Res. 3) which would have disapproved, under the Congressional Review Act, the fee schedule update published December 31, 2002. Under the Congressional Review Act, the Congress is given 60 days to disapprove the implementation of a major regulation. However, this authority has been exercised only once during the 6 years it has been in effect. Use of the authority under the Congressional Review Act would have had the effect of freezing the rates at the 2002 level until a revised regulation was issued. However, some observers, noted that H.J.Res. 3 would disapprove the entire fee schedule regulation, not just the update. They suggested that this could nullify some positive changes incorporated in the regulation.

The Senate addressed the issue by including a provision in its version of H.J.Res. 2 (the CAR) which would have frozen physician payments at the 2002 level through September 30, 2003. As noted earlier, the conference agreement of the CAR included a provision which had the effect of increasing the conversion factor for 2003 by 1.6%. The President signed the bill into law on February 20, 2003, P.L. 108-7. The provisions of the December rule not relating to the conversion factor continue to apply.

Other Issues

Access

Recently questions have been raised about beneficiaries continued access to care. Press reports in many part of the country have documented many cases where beneficiaries have been unable to find a physician because physicians in their area are refusing to accept new Medicare patients. The primary reason given was the 5.4% cut in the conversion factor in 2002. A number of physicians are claiming that program payments fall significantly short of expenses. Many observers contended that the problem would grow worse if an additional cut in payments had been allowed to go through in 2003.

Periodic analyses by PPRC, and subsequently MedPAC, as well as CMS showed that access to physicians' services generally remained good for most beneficiaries through 1999.[15] Detailed data is not available for a subsequent period; however, several surveys have shown a decline in the percentage of physicians accepting new Medicare patients. For example, a survey by the Center for Studying Health Systems Change reports that the percentage dropped from 72% to 68% from 1997 to 2001. The sharpest decline occurred for surgical specialists, while there was a modest increase for medical specialists. The declines were also sharpest for physicians with low Medicare revenues.[16] Another survey by American Family of Family Physicians reported that the number of physicians turning away new Medicare patients had jumped 28% (from 17% to 21.7% of surveyed physicians) over the figure recorded a year earlier.[17]

Geographic Variation in Payments

As noted earlier, Medicare makes a geographic adjustment to each component of the physician fee schedule.[18] This adjustment is intended to reflect the actual differences in the costs of providing services in various parts of the country. Recently some observers, particularly those in states with lower than average payment levels, have objected to the payment variation. In part, this may reflect the concern with the overall reduction in payment rates from 2001 to 2002. It should be noted that under current law any modifications to the geographic adjustments would

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[15] 1) Medicare Payment Advisory Commission. *Medicare Beneficiaries Access to Quality Health Care. Report to Congress: Medicare Payment Policy*. March 2000; and 2) Schoenman, Julie A., Kevin Hayes, and C. Michael Cheng. *Medicare Physician Payment Changes: Impact on Physicians and Beneficiaries*, Health Affairs, v. 20, no.2, March/April 2001.

[16] Center for Studying Health Systems Change. Testimony of Paul Ginsburg before the House Committee on Ways and Means, Subcommittee on Health, February 28,2002.

[17] [http://www.aafp.org], Number of Physicians Turning Away New Medicare Patients Jumps 28%. Press Release, July 24, 2002; accessed August 13, 2002.

[18] See the Appendix for a discussion of how these adjustments are calculated.

have to be budget neutral. Thus, if payments were increased for some areas, they would have to be offset by payment reductions in other areas.

Some have also suggested that states with lower than average per capita payments (excluding managed care payments) for all Medicare services are being shortchanged. It should be noted that the data reflect a variety of factors, few of which can be easily quantified. These include variations in practice patterns, size and age distribution of the beneficiary population, variations in managed care penetration, and the extent to which other federal programs (such as those operated by the Department of Defense or Veterans Affairs) are paying for beneficiaries care.[19]

Practice Expenses

Background. The relative value for a service is the sum of three components: physician work, practice expenses, and malpractice expenses. Practice expenses include both direct 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). When the fee schedule was first implemented in 1992, the calculation of work relative value units was based on resource costs. At the time, there was insufficient information to determine resource costs associated with practice expenses (and malpractice costs). Therefore payment for these items continued to be based on historical charges.

A number of observers felt that the use of historical charges provided an inaccurate measure of actual resources used. The Social Security Act Amendments of 1994 (P.L. 103-432) required the Secretary of Health and Human Services to develop a methodology for a resource-based system which would be implemented in CY1998. HCFA developed a proposed methodology which was published as proposed rule-making June 18, 1997. Under the proposal, expert panels would estimate the actual direct costs (such as equipment and supplies) by procedure; HCFA then assigned indirect expenses (such as office rent and supplies) to each procedure. This "bottom up" 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.

BBA 97. BBA 97 delayed implementation of the practice expense methodology while a new methodology was developed and refined. BBA 97 provided that only interim payment adjustments to existing historical charge-based practice expenses would be made in 1998. It established a process for the development of new relative values for practice expenses and provided that the new resource-based system would be phased-in beginning in CY1999. In 1999, 75% of the payment would be based on the 1998 charge-based relative value unit and 25% on the resource-based relative value. In 2000, the percentages would be 50% charge-based and 50% resource-based. For 2001, the percentages would be 25% charge-

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[19] For a further discussion of this issue see CRS Congressional Distribution memorandum: *Geographic Variation in Medicare Fee-For-Service Spending*, by Sibyl Tilson, April 9, 2002.

based and 75% resource-based. Beginning in 2002, the values would be totally resource-based.

New Practice Expense Relative Value Units. During 1998, HCFA developed a new methodology for determining relative values for practice expenses. This methodology, in use since the beginning of the phase-in process in 1999, has been labeled the "top down" approach. For each medical specialty, HCFA estimates aggregate spending for six categories of direct and indirect practice expenses using the American Medical Association's (AMA's) Socioeconomic Monitoring System (SMS) survey data and Medicare claims data. Each of the direct expense totals (for clinical labor, medical equipment, and medical supplies) are allocated to individual procedures based on estimates from the specialty's clinical practice expert panels (CPEPs). Indirect costs (for office expenses, administrative labor, and other expenses) are allocated to procedures based on a combination of the procedure's work relative value units and the direct practice expense estimates. If the procedure is performed by more than one specialty, a weighted average is computed; this average is based on the frequency with which each specialty performs the procedure on Medicare patients. The final step is a budget neutrality adjustment to assure that aggregate Medicare expenses are no more or less than they would be if the system had not been implemented.

Refinements. The "top down" approach was less controversial than the original "bottom up" approach proposed in 1997. However, a number of groups continued to express concerns, particularly with the perceived limitations in the survey data. In 1999, the General Accounting Office (GAO) issued a report on practice expenses; it had reviewed HCFA's methodology and concluded that it was acceptable for establishing practice expense relative values. GAO noted that HCFA used what were generally recognized as the best available data, namely the SMS annual survey and CPEP data. However, it noted that several data limitations had been identified and should be overcome.[20]

Supplemental Data. During the phase-in period, Congress and others continued to evidence concern regarding the survey data being used. BBRA 99 required the Secretary to establish by regulation a process (including data collection standards) for determining practice expense relative values. Under this process, the Secretary would accept for use and would use to the maximum extent practicable and consistent with sound data practices, data collected or developed outside HHS. These outside data would supplement data normally developed by HHS for determining the practice expense component. The Secretary would first promulgate the regulation on an interim basis in a manner that permitted submission and use of outside data in the computation of relative value units for 2001. The Secretary issued an interim final rule on May 3, 2000, for criteria applicable to supplemental survey data submitted by August 1, 2000; in addition a 60-day comment period was provided on these criteria. The November 1, 2000 final fee schedule regulation for 2001 incorporated modifications to the criteria.

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[20] U.S. GAO. *Medicare Physician Payments: Need to Refine Practice Expenses During Transition and Long Term.* Report to Congressional Committees. GAO/HEHS-99-30, February 1999.

In the November 1, 1999, final fee schedule regulation for 2000, HCFA accepted supplemental survey data from thoracic surgeons and in the November 1, 2000, final rule for 2001 accepted supplemental survey data from vascular surgeons. Three organizations submitted supplemental survey data for consideration for use in 2002. However, in the November 1, 2001, final rule for 2002, CMS decided not to use the data because none of the surveys met all of its stated criteria.[21] The final rule issued December 31, 2002 for 2003 accepted supplemental survey data from physical therapists.

Other Activities. CMS is continuing its refinement of practice expense relative value units. Assisting in this process is a multispecialty subcommittee of the AMA's RUC. This subcommittee, the Practice Expense Advisory Committee (PEAC), is reviewing CPEP clinical staff, equipment, and supply data for physicians' services. It makes recommendations to CMS based on this review. CMS has implemented most of the refinements recommended by the RUC and PEAC.

Legislation; GAO Studies. The Medicare, Medicaid, and SCHIP Benefits Improvement Act of 2000 (BIPA 2000) required GAO to conduct a study on refinements to practice expense relative value units during the transition to the full resource-based system in 2002. The study was to examine how the Secretary accepted and used practice expense data developed outside HHS (as required by BBRA 99). The report was also to include recommendations on: (1) improvements in the process for acceptance and use of outside data; (2) any change that is appropriate to ensure full access to a spectrum of care for beneficiaries; and (3) the appropriateness of payments for physicians. In a separate report, the Secretary was required to report on specialist services furnished in physicians' offices and hospital outpatient departments; the study was to assess whether resource-based practice expenses create an incentive to furnish services in physicians' offices rather than hospital outpatient departments. Both reports were due July 1, 2001. As of this writing these studies have not been issued, though GAO has released related studies on oncology payments. (See below)

Payments for Oncology Services

Background. The level of payments for practice expenses has become a major issue for oncologists who frequently administer chemotherapy drugs in their offices. In general, Medicare does not cover outpatient prescription drugs. However, certain categories of outpatient drugs are covered. Included are drugs which cannot be self-administered and which are provided as incident to a physician's service, such as chemotherapy.[22] A number of recent reports, including those by the HHS Office

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[21] U.S. DHHS. Centers for Medicare and Medicaid Services. *Medicare Program; Revisions to Payment Policies and Five-Year Review of and Adjustments to the Relative Value Units Under the Physician Fee Schedule for Calendar Year 2002*. Final rule. *Federal Register*, v. 66, no. 212, November 1, 2001.

[22] Medicare also covers certain oral cancer drugs. Covered drugs are those that have the same active ingredients and are used for the same indications as chemotherapy drugs which would be covered if they were not self-administered and were administered as incident to

(continued...)

of Inspector General and the Department of Justice (DOJ) have found that Medicare's payments for some of these drugs are substantially in excess of physicians' and other providers' costs of acquiring them. However, oncologists have stated that the overpayments on the drug side are being used to offset underpayments for practice expenses associated with administration of the chemotherapy drugs.

Medicare payment for drugs equals 95% of the average wholesale price (AWP). AWPs are "list prices" set by drug manufacturers.[23] The Inspector General and the DOJ found that AWPs are often substantially in excess of actual acquisition costs. In response, HCFA issued a memorandum in September 2000 authorizing the use of prices obtained by the DOJ to set Medicare payments for certain categories of drugs. The memorandum included pricing information for oncology drugs, but stated that the information was not to be used to set payments them. However, oncologists continued to voice concerns. HCFA withdrew the policy in November 2000. Further, BIPA 2000 prohibited the Secretary from implementing any payment reduction for drugs until GAO prepared and the Secretary reviewed a report on revised payment methodologies for drugs. (See below)

Required GAO Reports. BBRA 99 required GAO to conduct a study on the resources required to provide safe and effective outpatient cancer therapy. In making the determination, the GAO was required to determine the adequacy of: (1) practice expense relative value units associated with the utilization of such clinical resources; and (2) work units which are used in the practice expense formula.

BIPA 2000 required GAO to prepare another report, to be coordinated with the report required by BBRA 99. The report required by BIPA 2000 was to include recommendations on revised payment methodologies for drugs. The report could include: (1) proposals to make adjustments to the practice expense component for the costs incurred in the administration, handling, or storage of certain categories of drugs, and (2) proposals for new payments to providers or suppliers for such costs, if appropriate.

On September 21, 2001, GAO issued a report on Medicare drug payments. The report again noted that physicians are generally able to obtain Medicare-covered drugs at prices significantly below current Medicare payments.

> ... For most physician-administered drugs, the average discount from AWP ranged from 13 to 34%... Our survey of physicians who billed Medicare for low volumes of drugs used in cancer treatment indicated they received discounts that were as large or larger than widely available discounts for 11 of the 16 products for which they were able to produce price information. Physicians are reimbursed under the physician fee schedule for the costs of administering chemotherapy drugs, which account for most of Medicare's drug spending. HCFA deviated from the basic methodology for determining practice expense payments for certain services, including chemotherapy administration by

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[22] (...continued)
a physician's professional service.

[23] For a discussion of AWP, see: CRS Report RL31419, *Medicare: Payments for Covered Prescription Drugs*, by Jennifer O'Sullivan.

> nonphysicians, which reduced Medicare's practice expense payment for most chemotherapy administration services. However, even with this alternative methodology, oncologists' average practice expense payments in 2001 are 8% higher than what they would have been had charge-based payments continued.[24]

In October 2001, GAO issued its report on practice expense payments for oncologists. This report again cited the 8% higher payments and expanded on the information provided in the September report.

> ... Oncology's practice expense payments compared to their estimated practice expenses are about the same as the average for all physicians. Oncology representatives continue to have concerns that the data HCFA used and the adjustments it made result in their practice expenses, and consequently their payments, being understated. For example, HCFA appropriately reduced oncology's reported supply expenses to exclude the costs of drugs, which are paid for separately, before calculating practice expense payments. However, HCFA based its reduction on average physician supply expenses rather than on oncology's supply expenses. An adjustment based on oncology-specific information may result in higher payments to oncologists. Addressing other data and methodological issues raised by oncologists would have an uncertain impact on oncologists' payments under the fee schedule ...[25]

As noted above, CMS has established a methodology for determining practice expenses across specialties. Some observers felt that this methodology resulted in low payments for certain services (such as many chemotherapy administration services) which do not have direct physician involvement. In response, CMS developed an alternative methodology for determining these costs. Contrary to expectations, the alternative method resulted in reduced payments for some of these nonphysician services; at the same time payments for services with direct physician involvement increased.

The GAO recommended that CMS examine the effect, across all specialties and classes of services, of the adjustments made to the basic methodology. It further recommended that it improve the allocation of indirect expenses across all services. In addition, it recommended using the basic method for calculation of payments for services without direct physician involvement, and, if necessary validating the underlying resource-based estimates of direct practice expenses for all nonphysician services. In March 2002, the GAO reported that if these recommendations had been followed, oncologists would have been paid about $51 million more in 2001.

GAO is currently working on a congressionally-mandated report on practice expenses (see above). That report is expected to examine the issues related to the adequacy of the data underlying practice expense payments for all services and ways CMS could improve these data. That study is expected to involve discussion with a variety of physician organizations.

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[24] U.S. GAO. *Medicare: Payments for Covered Outpatient Drugs Exceed Providers' Cost.* Report to Congressional Committees. GAO-01-1118, September 21, 2001.

[25] U.S. GAO. *Practice Expense Payments to Oncologists Indicate Need for Overall Refinements*. Report to Congressional Committees. GAO-02-53, October 2001.

It must be remembered that any reallocation of payments among services must still meet budget neutrality requirements. The use of more current or accurate practice expenses data would also have an impact on practice expense relative values for other services. It is not clear what the net impact would be for oncologists. The practice expense relative values for oncology services versus other services could potentially increase, decrease, or remain relatively unchanged. Therefore, payments for these services could also potentially increase, decrease, or remain relatively unchanged.

Documentation for Evaluation and Management Services

Approximately 40% 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 are 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. That report stated that in FY1996, there were $23 billion in questionable Medicare payments for all service categories (14% of total fee-for-service payments); 47% of these were attributed to documentation problems. Improper payments have declined. The 2002 report estimated that there were $12.1 billion in improper payments in FY2001 (6.3% of total fee-for-service spending); of this amount 42.9% (the highest percentage in 4 years) were attributed to documentation problems.[26]

Initial evaluation and management documentation guidelines were issued in 1995. Subsequently, HCFA worked with the AMA to develop a new set of guidelines. These guidelines were first released in May 1997 and subsequently revised in November 1997. The guidelines detailed for the first time specific medical documentation requirements for single-organ system examinations and included slightly stricter clinical standards for multisystem exams. Proponents of increased medical record documentation considered it an important element contributing to high quality patient care. They contended that an appropriately documented record would 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 was expected to assist physicians who are audited by carriers and could serve, if necessary, as a legal document to verify the care provided.

Many physicians have viewed the guidelines as cumbersome and an interference to patient care. In an effort to respond to these concerns, HCFA released new draft documentation guidelines in June 2000 and updated them in December 2000. HCFA described this version as simpler than the previous versions. The agency stated that it intended to pilot test the guidelines after it developed, in conjunction with a contractor (Aspen Systems), clinical examples illustrating the guidelines. This

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[26] U.S. DHHS. Office of the Inspector General. *Improper Fiscal Year 2001 Medicare Fee-For Service Payments*. Report A-17-01-02002, February 21, 2002.

process continued to prove controversial with many physicians arguing that the guidelines continued to be unworkable. The AMA stated that:

> The E&M guidelines continue to be an extremely burdensome problem for physicians. In a recent AMA survey, three-fifths of respondents identified these guidelines as the most onerous Medicare paperwork burden. Many physicians regard the guidelines and associated clinical examples... as "overly complex" and "unworkable." We have reached the point where physicians create documentation in their patients' charts often not for the benefit of the patients' care, but purely to meet the government's demands. These regulatory requirements have resulted in voluminous charts filled with layers and layers of extraneous information. In fact, this additional documentation in patients' charts can actually hurt patients since care is unnecessarily delayed while physicians are forced to search through pages and pages of documentation to identify the truly relevant information. It is like trying to find the needle in the haystack, and when a patient needs emergency treatment, for example, physicians do not have the luxury of researching voluminous patient records. The pertinent medical information needs to be immediately available so that the patient can be treated appropriately. The current E&M documentation requirements make this nearly impossible.[27]

On July 19, 2001, Secretary Thompson announced that HHS would step back and reexamine the whole issue.

> We had hoped that this current effort would be a way to reduce burdens on physicians, but it appears it needs another look. So I have directed Aspen Systems to stop their work on this current draft while we reassess and re-tune our effort. Additionally, I am turning to the physician community to help design constructive solutions. After 6 years of confusion, I think it makes sense to try to step back and assess what we are trying to achieve. We need to go back and re-examine the actual codes for billing doctor visits. For the system to work, the codes for billing these visits need to be simple and unambiguous. I look forward to working with the AMA and other physician groups to simplify the codes and make them as understandable as possible.[28]

Private Contracting

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 can bill patients at their discretion without being subject to upper payment limits specified by Medicare. HCFA (now CMS) 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

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[27] AMA. *AMA Statement to the Practicing Physicians Advisory Council re: E&M Guidelines and Other Issues*. Statement submitted June 25, 2001. [http://www.ama-assn.org/ama/pub/article/4077-5048html] (accessed October 17, 2001)

[28] Thompson, Tommy G. Testimony before the House Committee on Ways and Means, Hearings on Administration's Principles to Strengthen and Modernize Medicare, July 19, 2001.

private contract with a Medicare patient, that physician must agree to forego any reimbursement by Medicare for all Medicare beneficiaries 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.

How Private Contracting Works. HCFA issued regulations November 2, 1998 (as part of the 1999 physician fee schedule regulations) which clarified private contracting requirements. The following highlights the major features of private contracting arrangements.

- *Physicians and Practitioners*. A 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.

- *Beneficiaries*. Private contracting rules apply only to persons who have Medicare Part B.

- *Contract Terms*. The contract between a physician and a patient must: (1) 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; (2) indicate if the physician or practitioner has been excluded from participation from Medicare under the sanctions provisions; (3) 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; and (4) state that the beneficiary has the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted-out and that the beneficiary is not compelled to enter into private contracts that apply to other services provided by physicians and practitioners who have not opted-out. 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: (1) provide that the physician or practitioner will not submit any claim to Medicare for 2 years; (2) 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 under*

Medicare+Choice; (3) acknowledge that during the opt-out period services are not covered under Medicare and no Medicare payment may be made to any entity for his or her services; (4) identify the physician or practitioner (so that the carrier will not make inappropriate payments during the opt out period); (5) be filed with all carriers who have jurisdiction over claims which would otherwise be filed with Medicare; (6) acknowledge that the physician understands that a beneficiary (who has not entered a private contract) who requires emergency or urgent care services may not be asked to sign a private contract prior to the furnishing of those services; and (7) be in writing and be signed by the practitioner.

- *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 and routine physical exams.

- *Services Not Covered in Individual Case*. A physician or practitioner may furnish a service that Medicare may cover under some circumstances but which the physician or practitioner anticipates would not be considered "reasonable and necessary" in the particular case (for example, multiple visits to a nursing home). If the beneficiary receives an *Advance Beneficiary Notice" (ABN)* 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. There are no limits on what may be charged for the non-covered service.

- *Medicare+Choice and Private Contracting*. A private contracting physician may not receive payments from a Medicare+Choice organization for Medicare-covered services provided to plan enrollees under a capitation arrangement.

- *Ordering of Services*. Medicare will pay for services by one physician which has been ordered by a physician who has entered a private contract (unless such physician is excluded under the sanctions provisions). The physician who has opted out may not be paid directly or indirectly for the ordered services.

- *Timing of Opt-Out*. Participating physicians can enter a private contract, i.e. "opt out," at the beginning of any calendar quarter, provided the affidavit is submitted at least 30 days before the beginning of the selected calendar quarter. Nonparticipating physicians can opt out at any time.

- *Early Termination of Opt-Out*. A physician or practitioner can terminate an opt-out agreement within 90 days of the effective date of the first opt out affidavit. To properly terminate an opt-out, the individual must: (a) notify all carriers with which he or she has filed an affidavit within 90 days of the effective date of the opt-out

period; (b) refund any amounts collected in excess of the limiting charge (in the case of physicians) or the deductible and coinsurance (in the case of practitioners); (c) inform patients of their right to have their claims filed with Medicare for services furnished during the period when the opt-out was in effect. In addition, there was a one time opportunity for physicians who completed opt-out before January 1, 1999 to terminate the opt-out during the first 90 days of 1999. (This was to allow an individual to change a previous opt-out decision based on the November 1998 regulations.)

Current Issues. Prior to passage of the BBA provision, HCFA had interpreted Medicare law to preclude private contracts. Proponents of private contracting argued that private contracting is a basic freedom associated with private consumption decisions. Patients should be allowed to get services from Medicare and not have Medicare billed for the service. Advocates of private contracting generally object to Medicare's payment levels and balance billing limitations. They state that if Medicare is not paying the bill, physicians who choose to private contract should not be governed by Medicare's rules.

Opponents of private contracting contend that the ability to enter into private contracts benefits the pocketbooks of physicians and creates a "two-tiered system" — one for the wealthy and one for other Medicare eligibles. The two-tiered system would allow wealthier beneficiaries to seek care outside of Medicare and could conceivably create a situation where only wealthier beneficiaries have access to the Nation's, or an area's, leading specialists for a medical condition. A further concern is that beneficiaries living in areas served by only private contracting specialists would be unable to afford the bill (which could be any amount) and therefore forgo needed care.

The BBA 97 provision provided a limited opportunity for private contracting. However, the 2-year exclusion proved very controversial. Proponents of private contracting view the 2-year exclusion as a disincentive to enter these arrangements. They argue that physicians should not be excluded entirely from Medicare because of their decision to contract in an individual case. Other observers are concerned that removal of the 2-year limit would place beneficiaries at risk. They contend that more physicians would elect to private contract if they could do it on a service-by-service basis. Beneficiaries might not know sufficiently in advance whether or not a particular service would or would not be paid by Medicare. Following enactment of the private contracting provision in 1997, some efforts were made to eliminate the 2-year exclusion. However, the provision has not been amended or repealed.

Current Prospects

The negative update for physician payments in 2002 concerned a number of Members of Congress. Many heard reports of some physicians not taking new Medicare patients. Despite the fact that most Members agreed that the payment issue should be addressed, the 107th Congress did not take final action. This was because the Congress was unable to come to agreement on the scope of a Medicare bill.

Many Members were unwilling to pass a bill that addressed only physician payment issues without also increasing payments for some other health care provider categories. At the same time, the Administration wanted only a limited provider "give-back" bill. Further, many Members expressed reluctance to pass any "give-back" measure without enacting a drug benefit for beneficiaries.

These same issues faced the 108th Congress. However, as noted previously, the Congress passed, and the President signed into law, the CAR (P.L.108-7) which had the effect of increasing the conversion factor for 2003. However, this law does not address the underlying issues related to application of the formula for the annual payment update. It is possible that the Congress may look at this issue later this year as part of the overall discussion on Medicare reform issues. However, it is difficult to predict the scope and timing of any final legislation.

Appendix: Geographic Adjustments to the Physician Fee Schedule

Section 1848(e) of the Social Security Act requires the Secretary of the Department of Health and Human Services (HHS) to develop indices to measure relative cost differences among fee schedule areas compared to the national average. Three separate indices are required – one for physician work, one for practice expenses and one for malpractice costs. The law specifies that the practice expense and malpractice indices reflect the full relative differences. However, the work index must reflect only *one-quarter* of the difference. Using only one-quarter of the difference generally means that rural and small urban areas would receive higher payments and large urban areas lower payments than if the full difference were used. The indices are updated every 3 years and phased-in over 2 years.

Legislative Background

The physician fee schedule represented the culmination of several years of examination by the Congress, HHS, and other interested parties on alternatives to the then existing charge-based reimbursement system. In 1986, Congress enacted legislation providing for the establishment of the Physician Payment Review Commission (PPRC) to provide it with independent analytic advice on physician payment issues. A key element of the Commission's charge was to make recommendations to the Secretary of HHS respecting the design of a relative value scale for paying for physicians services. The Commission's March 1989 report presented the Commission's proposal for a fee schedule based primarily on resource costs. It recommended that the initial basis for the physician work component should be the work done by William Hsiao and his colleagues at Harvard University.

The 1989 PPRC report examined issues related to geographic variations. It noted that adjustments could be made to reflect nonphysician inputs (overhead costs such as office space, medical equipment, salaries of nonphysician employees, and malpractice insurance) and physician inputs of their own time and effort (which is generally measured by comparing earnings data of nonphysicians). It concluded that:

> Payments under the fee schedule should vary from one geographic locality to another to reflect variation in physician costs of practice. The cost-of-living practice index underlying the geographic multiplier should reflect variation only in the prices of nonphysician inputs.[29]

PPRC stated that the fee schedule should only reflect variation in overhead costs. Other observers, however, suggested that since physicians, as well as other professionals, compete in local markets, local market conditions should be reflected in the payments.

Three congressional committees have jurisdiction over Medicare Part B (which includes physicians services). These are the House Energy and Commerce, House Ways and Means, and Senate Finance. Each of these committees considered

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[29] Physician Payment Review Commission, *Annual Report to Congress 1989*. 1989.

differing versions of the physician fee schedule as part of the budget reconciliation process in 1989. Both the Ways and Means Committee measure and the Senate Finance Committee measure included a geographic adjustment for the overhead and malpractice components of the fee schedule, but not for the physician work component. However, the Energy and Commerce Committee version provided for an adjustment. The Committee noted:

> The PPRC, in its annual report for 1989, recommended that the physician work effort component of the fee schedule not be adjusted at all for geographic variations, on the grounds that the physician's time and effort should be given the same valuation everywhere in the country. The Committee does not agree with this recommendation. The Committee recognizes that the cost-of-living varies around the country and that other professionals are compensated differently, based on where they perform their services. The Committee is concerned that, if no adjustment is made in the physician work effort component, fees in high cost areas may be reduced to such an extent that physician services in such areas would become inaccessible. The Committee is also concerned, however, that a full adjustment of this component, in accord with the index developed by the Urban Institute, would be disadvantageous to the low valuation areas and would not serve the Committee's policy goal of fostering a better distribution of physician personnel. Fees in those areas might be too low to attract physicians and to resolve problems of access that have occurred.
>
> The index chosen by the Committee tries to balance these concerns. It makes the adjustment in the physician work effort component, but cuts the impact of the original Urban Institute index in half ...[30]

The reconciliation bill passed by the House included both the Ways and Means Committee and Energy and Commerce Committee versions of reform. The Senate Finance Committee version was not in the Senate-passed version because all Medicare and non-Medicare provisions which did not have specific impact on outlays (and therefore could not withstand a point of order based on the "Byrd rule") were struck from the Senate bill. Since the physician payment reform provisions were designed to be budget neutral they were not included. Therefore, the Senate physician fee schedule provisions were not technically in conference.

After considerable deliberation, the conference committee approved a reconciliation bill which included physician payment reform. The conference agreement provided that one-quarter of the geographic differences in physician work would be reflected in the fee schedule. The accompanying report described the provision but contained no discussion of this issue.

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[30] U.S. Congress. House. Committee on the Budget. *Omnibus Budget Reconciliation Act of 1989*. Report to accompany H.R. 3299. September 20, 1989.

Calculation [31]

Work Component. The law defines the physician work component as the portion of resources used in furnishing the service that reflects physician time and intensity. The geographic adjustment to the work component is measured by net income. The data source used for making the geographic adjustment has remained relatively unchanged since the fee schedule began in 1992. The original methodology used median hourly earnings, based on a 20% sample of 1980 census data of workers in six specialty occupation categories with 5 or more years of college. (At the time, the 1980 census data were the latest available.) The specialty categories were: (1) engineers, surveyors, and architects; (2) natural scientists and mathematicians; (3) teachers, counselors, and librarians; (4) social scientists, social workers, and lawyers; (5) registered nurses and pharmacists; and (6) writers, artists, and editors. Adjustments were made to produce a standard occupational mix in each area. HHS has noted that the actual reported earnings of physicians were not used to adjust geographical differences in fees, because these fees in large part are the determinants of earnings. HHS further stated that they believed that the earnings of physicians will vary among areas to the same degree that the earnings of other professionals will vary.

Calculations for the 1995 through 1997 indices also used a 20% census sample of median hourly earnings for the same six categories of professional specialty occupations. However, the 1990 census no longer used a sample of earnings for persons with 5 or more years of college. For 1990, data were available for all – education and advanced degree samples. HHS selected the all education sample because it felt the larger sample size made it more stable and accurate in the less populous areas. The 1995 through 1997 indices also replaced metropolitan-wide earnings with county-specific earnings for consolidated metropolitan statistical areas (CMSAs) which are the largest metropolitan statistical areas.

Virtually no changes were made in the 1998 through 2000 work indices from the indices in effect for 1995 through 1997. Similarly, virtually no changes were made in the 2001-2003 work indices.[32] This was because new census data were not available. HHS examined using other sources (including the hospital wage index used for the hospital prospective payment system); however, for a variety of reasons, it was unable to find one that was acceptable. It felt that making no changes was preferable to making unacceptable changes based on inaccurate data. It further noted that updating from the 1980 to 1990 census (for the 1995-1997 indices) had generally resulted in a small magnitude of changes in payments. Presumably, the 2004-2007 update will be able to use the 2000 census data.

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[31] Much of the discussion in this section is drawn from: (1) Medicare Program; Revisions to Payment Polices Under the Physician Fee Schedule for Calendar year 2001; Proposed Rule. *Federal Register*, v. 65, no 137, July 17, 2000. p. 44189-44196; and 2)Medicare Program; Revisions to Payment Polices Under the Physician Fee Schedule for Calendar year 2001; Final Rule. *Federal Register*, v. 65, November 1, 2000. p. 65404.

[32] In both cases very slight, very technical adjustments were made.

Practice Expense Component. The geographic adjustment to the practice expense component is calculated by measuring variations for three categories: employee wages, office rents, and miscellaneous.

Employee wages are measured using median hourly wages of clerical workers, registered nurses, licensed practical nurses, and health technicians. Initially a 20% sample of the 1980 census data were used. The 1990 census was used for the 1995-1997 revision. As is the case for calculating the work indices, changes will only be made when the 2000 census data become available. HHS again noted that updating from the 1980 to 1990 census (for the 1995-1997 indices) had generally resulted in a small magnitude of changes in payments. As was the case for the work indices, the 1995 to 1997 indices provided for the use of county-specific earnings for CMSAs.

Office rents are measured by using residential fair market rental (FMR) data for residential rents produced annually by the Department of Housing and Urban Development (HUD). Commercial rent data has not been used because HHS has been unable to find data on commercial rents across all fee schedule areas.

The 2001-2003 indices are based on 2000 FMR data. HUD publishes the data on a metropolitan area basis. It made a special county-specific calculation, based on 1990 census data, for the 1995-1997 indices. Beginning with the 1998-2000 indices, HHS decided, for a variety of reasons, that county-specific data should not be retained except for the New York City area.

The costs of medical equipment, supplies, and miscellaneous expenses are assumed not to vary much throughout the country. Therefore, this category has always been assigned the national value of 1.000.

Malpractice component. Malpractice premiums are used for calculating the geographic indices. Premiums are for a mature "claims made" policy (a policy that covers malpractice claims made during the covered period) providing $1 million to $3 million coverage. Adjustments are made to incorporate costs of mandatory patient compensation funds. Initially, premium data were collected for three risk classes: low risk (general practitioners), moderate risk (general surgeons), and high risk (orthopedic surgeons). Subsequently data was collected on more specialties and from more insurers. An average of 3-years of data is used to smooth out year-to-year fluctuations. Premiums data for 1996-1998 was used for the 2001-2003 indices.