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Medicare: Payments to Physicians

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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. Additional reductions were slated to go into effect in 2003, 2004, and 2005, but were prevented by congressional action. Many Members were concerned about the potential impact of payment reductions on patients' access to services.

Medicare payments for services of physicians and certain nonphysician 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 are estimated at $58.1 billion in FY2006 (over one-sixth of total benefit payments). The fee schedule assigns relative values to services that 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 2005 is $37.8975, a 1.5% increase over the 2004 level, but, 0.9% less than the 2001 level ($38.2581).

The fee schedule places a limit on payment per service but not on overall volume of services. The formula for calculating the annual update to the conversion factor responds to changes in volume. If the overall volume of services increases, the update is lower; if the overall volume is reduced, the update is higher. The intent of the formula is to place a restraint on overall increases in Medicare spending for physicians' services. Several factors enter into the calculation. 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 and 2004; however, legislation prevents this from occurring through 2005. Congress has not, however, addressed the underlying issues related to application of the formula for the annual payment update. As a result, in the absence of congressional action, a negative update is expected in 2006.

On December 8, 2003, the President signed into law the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173). In addition to including a new prescription drug benefit, the law contains numerous changes to the existing Medicare program. It makes a variety of modifications to payment rules for fee-for-service providers, including physicians. The law specifically provides that the updates for 2004 and 2005 can not be less than 1.5%. Further, it contains other provisions designed to increase physician payments. This report will be updated as events warrant.

Contents

List of Tables

Medicare: Payments to Physicians

Introduction: Medicare Fee Schedule

Medicare is a nationwide program which offers health insurance protection for 42 million aged and disabled persons. Currently, 87% 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 13% of beneficiaries are enrolled in managed care organizations, under the Medicare Advantage program (formerly known as 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 $56.5 billion in FY2005 and $58.1 billion in FY2006 (over one-sixth of total Medicare benefit payments).[1]

The law specifies a formula for the annual update to the physician fee schedule. Part of this update is based on whether spending in a prior year has exceeded or fallen below a spending target. The target (known as the sustainable growth rate (SGR)) is essentially a cumulative target for Medicare spending growth over time. If spending is in excess of the target, the update for a future year is reduced; the goal is to bring spending back in line with the target. Application of the update formula would have led to a negative update for each year beginning in 2002. The update for 2002 was a *negative* 5.4%. However, Congress overrode the application of the formula for 2003, 2004, and 2005. Absent additional congressional action, the update for 2006 is estimated to be a *negative* 4.3%. Updates for subsequent years are also expected to be negative.

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[1] Excludes payments for prescription drugs under the new Medicare Part D program. Congressional Budget Office, March 2005 baseline.

Why the Fee Schedule Was Enacted

The fee schedule, established by the Omnibus Budget Reconciliation Act of 1989 (OBRA 1989, P.L. 101-239), 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.

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] These are added together to produce an indexed relative value unit for the service for the locality.[3] There are 89 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 2005 conversion factor is $37.8975. Thus, the payment for a service with an adjusted relative value of 2.3 is $87.16.[5] Anesthesiologists are paid under a separate fee schedule which uses base and time units; a separate conversion factor ($17.7594 in 2005) applies.

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 paid only if the services are actually provided in the HPSA, as designated under the Public Health Service Act. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) requires the Secretary to pay automatically the bonus for services furnished in full county primary care geographic area HPSAs rather than having the physician identify that the services were furnished in such area.

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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. A value of 1.00 represents an average across all areas. MMA placed a floor of 1.00 on the work adjustment for the 2004-2006 period; areas that would otherwise have a value below 1.0 (primarily rural areas) will receive higher payments over the period.

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

[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, P.L. 105-33) 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.

MMA also provides for an additional 5% in payments for certain physicians in scarcity areas for the period January 1, 2005 through December 31, 2007. The Secretary is required to calculate, separately for practicing primary care physicians and specialists, the ratios of such physicians to Medicare beneficiaries in the county, rank each county (or equivalent area) according to its ratio for primary care and specialists separately, and then identify those scarcity areas with the lowest ratios which collectively represent 20% of the total Medicare beneficiary population in those areas. The list of counties will be revised no less often than once every three years unless there are no new data. There will be no administrative or judicial review of the designation of the county or area as a scarcity area, the designation of an individual physician's specialty, or the assignment of a postal zip code to the county or other area.

The listing of counties for 2005 appear in Appendix I and Appendix J of the 2005 physician fee schedule update.[6]

Publication of Fee Schedule. Medicare is administered by the Centers for Medicare and Medicaid Services (CMS).[7] 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 three years.

The fee schedule is generally published by November 1 and is effective January 1. The final fee schedule for 2005 was issued November 15, 2004.

Beneficiary Protections

Medicare pays 80% of the fee schedule amount for physicians' services after beneficiaries have met the annual Part B deductible ($110 in 2005). Beneficiaries are responsible for the remaining 20%, known as coinsurance. A physician may choose whether to accept **assignment** on a claim.[8] 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

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[6] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services. Medicare Program; Revision to Payment Policies Under the Physician Fee Schedule Update for Calendar Year 2005; Final Rule, 69 *Federal Register* 66235, Nov. 15, 2004.

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

[8] 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 to accept assignment.

physician" does not mean that the physician doesn't deal with Medicare. Nonparticipating physicians can 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 physicians (which is only 9.25% higher than the amount recognized for participating physicians i.e., 115% x .95 = 1.0925). (See **Table 1)**

In 2004, 92% of physicians (and limited licensed practitioners) billing Medicare were participating physicians. Approximately 99% of Medicare claims were assigned in 2003.[9]

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

[9] MedPAC, *Medicare Payment Policy*, Report to the Congress, Mar. 2005. (Hereafter cited as MedPAC, Mar. 2005.)

Type of physician and claim	Medicare pays	Beneficiary pays	Balance billing charges
(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%)

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.

Submission of Claims

Physicians and practitioners are required to submit all claims for *covered* services to Medicare carriers. These claims must be submitted within one 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**)

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.[a]
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.

a. 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 Appendix D). In this case, physicians are precluded from billing Medicare or receiving any payment from Medicare for two years.

Refinements in Relative Value Units

On average, the work component represents 52.5% of a service's relative value, the practice expense component represents 43.6%, and the malpractice component represents 3.9%.[10] 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

[10] Ibid.

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 five years. The 1997 fee schedule update reflected the results of the first five-year review. The 2002 fee schedule reflected the results of the second five-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. The Balanced Budget Act of 1997 (BBA 97, P.L. 105-33) delayed its implementation. It provided for a limited adjustment in practice expense values for certain services in 1998. It further provided for implementation of a new resource-based methodology to be phased-in beginning in 1999. The system was fully phased in by 2002. (See *Appendix C*)

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 cumulative target for Medicare spending growth over time (with 1996 serving as the base period); (2) the Medicare economic index (MEI) which measures inflation in the inputs needed to produce physicians' services; and (3) the performance 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 the SGR is intended to serve as a restraint on aggregate spending. The SGR targets are not limits on expenditures. Rather the SGR represents a glidepath for desired cumulative spending from April 1996 forward. The fee schedule update reflects the success or failure in meeting the goal. If spending over the period is above the cumulative spending target for the period, the update for a future year is reduced. If expenditures are less than the

target, the update is increased. If expenditures equal the target, the update would equal the change in the MEI.

General Rules

The annual percentage update to the conversion factor, equals the MEI, subject to an adjustment (known as the performance adjustment) to match target spending for physicians' services established under the SGR system.[11]

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 Advantage 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. In order to even out large fluctuations, MMA changed the GDP calculation from an annual change to an annual average change over the preceding 10 years (a "10-year rolling average").

Performance Adjustment Factor. The performance adjustment sets the conversion factor at a level so that projected spending for the year will meet allowed spending by the end of the year. Allowed spending for the year is calculated using the SGR.

The technical calculation of the adjustment factor has changed several times. Since 2001, the adjustment factor has been the sum of: (1) the *prior year adjustment component*, and (2) the *cumulative adjustment component*.[12] 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.

In no case can the adjustment factor be less than minus 7% or more than plus 3%. Thus, despite calculations which would have led to larger reductions, the formula adjustment has been minus 7% for the last several years. However, Congress has overridden the formula calculation for 2003-2005.

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

[12] 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 Apr. 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 performance adjustment factor is to be determined; and (3) multiplying that amount by 0.33.

Recent Updates

Calculation for 2002. 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) was 5.4% less than the conversion factor for 2001 ($38.2581).

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 were made through adjustments to the conversion factor. Thus, the final update to the conversion factor was: -5.4%.

Calculation For 2003. 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 was 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 was 1.6%.

Calculation for 2004. In March 2003, CMS estimated that the 2004 update to the conversion factor would be a *negative 4.2%*. The primary factor contributing to the negative update was that spending for physicians' services in 2002 increased faster than the target and was expected to stay above the target through 2003. Therefore the update for 2004 would need to be lowered to place cumulative spending in line with the target. In November 2003, CMS issued its final fee schedule regulation[13] which set the update at a *negative* 4.5%, an even larger reduction than had been contemplated earlier in the year.

Enactment of MMA superceded the update specified in the November 2003 regulation. It specified that the update for 2004 and 2005 could not be less than 1.5%. On January 7, 2004, CMS issued revised regulations which reflected a number of MMA provisions. It set the update at 1.5%. Thus, the conversion factor for 2004 was set at $37.3374.

Calculation for 2005. On November 15, 2004, CMS announced that the fee schedule update would be 1.5%, the minimum allowed by the MMA provision. In the absence of the MMA provision, the update would have been a *negative* 3.3%.

Calculation for 2006. Absent further statutory changes, it is estimated that the updates will be negative beginning in 2006. CMS has provided a preliminary estimate of minus 4.3%. (This is based on an estimated 2.9% MEI increase and a minus 7% performance adjustment.)

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[13] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services. Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2004; Final Rule, 68 *Federal Register* 63245, Nov. 7, 2003.

Changes Made by MMA

MMA included a number of provisions relating to physicians' services. It included changes in the calculations of the fee schedule, increased payments for the administration of covered drugs, and included requirements for a number of reports on physician payment issues. (**For a detailed summary of these MMA provisions, See Appendix A.**)

Fee Schedule Modifications

MMA made several changes in the calculation of the fee schedule. Of particular importance is the provision that the annual update in 2004 and 2005 can be no less than 1.5%. Over the short term, generally 2004-2005, the fee schedule provisions are designed to increase program payments to physicians. They do not however, address the underlying problems with the formula used to calculate program payments under the fee schedule. (**See *Issues* section, below.**)

Drug Administration Services

Provisions. One of the main physician-related issues under discussion during the development of MMA was the appropriate amount to be paid for those drugs currently covered under Part B and the amounts to be paid to physicians in connection with the administration of such drugs. It was generally agreed that payments for the actual drugs were too high while the payments for drug administration were too low.

MMA revises the way covered Part B drugs are paid under the program; this has the effect of lowering program payments for the actual drugs.[14] At the same time, MMA increases the payments associated with drug administration services. These provisions affect selected specialties, primarily oncologists. The level of payments continues to be of concern to some oncologists. (**See *Issues* section, below**).

Studies and Reports

MMA also requires a number of studies and reports relating to physicians' services. These are designed to provide Congress with additional information as it considers revisions in the current payment formula.

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[14] CRS Report RL31419, *Medicare: Payments for Covered Part B Drugs*, by Jennifer O'Sullivan.

Issues

Calculation of the Update to the Conversion Factor

The negative update for 2002, the possibility that the 2003, 2004, and 2005 updates would also have been negative, as well as the current estimate of negative updates beginning in 2006 have raised concerns for many observers. There is increasing concern that some physicians may be unwilling to accept new Medicare patients (see Access discussion). 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 the Omnibus Budget Reconciliation Act of 1989 (OBRA 89, P.L. 101-239) 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 Medicare 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; this was intended to eliminate some of the year to year fluctuations.

Current Concerns. 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%.[15] However, beginning in 2002, the formula would have resulted in a negative update. The negative update was allowed to go into effect in that year. However, Congress overrode the negative updates that would have otherwise occurred in 2003, 2004, and 2005. Under current law, a negative update will apply in 2006, unless Congress again overrides application of the SGR rules.

SGR Issues. Many observers contend that the SGR system is flawed and should therefore not be used in making the annual update calculation. In 2001, MedPAC , which replaced the PPRC, 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 occurs, payments will either be too low, potentially jeopardizing beneficiary access to care, or too high, making spending higher than necessary.[16]

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.)[17]

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[15] Centers for Medicare and Medicaid Services (CMS), *CMS Announces Physician Pay Changes for 2002*, press release, Oct. 31, 2001.

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

[17] There was a further problem with the SGR system. When CMS issued its December 2002 regulation for 2003, 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

(continued...)

Subsequent MedPAC reports have continued to recommend an update based on changes in input prices minus an adjustment for productivity growth. The March 2005 report recommends a 2006 update reflecting changes in input prices (currently estimated at 3.5%) minus a 0.8% adjustment for productivity growth.[18]

It should be noted that a negative update to the conversion factor does not mean an overall reduction in physician spending. CBO estimates that spending under the fee schedule will climb from $52.0 billion in FY2004 to $60.8 billion in 2010.[19] While part of the increase is attributable to increasing numbers of beneficiaries, part reflects the increased volume of services per beneficiary. Volume increased by more than 30% between 1993 and 1998 and nearly 22% from 1999 to 2003.[20] Part of the increases in volume may be attributable to beneficial uses of new technology; however, not all increases may be appropriate.

Spending Trends. Recent increases in Medicare spending under the fee schedule mean that the difference between actual spending and the cumulative target continues to grow larger, therefore making continued negative updates more likely. The increase from 2003 to 2004 was significant. Despite the relatively modest increase in the conversion factor, Medicare payments for physicians' services increased an estimated 15%. CMS attributed the vast majority (over 95%) of the spending growth to five areas: office visits, with a shift toward longer and more intensive visits (29%of increase) more use of minor procedures including therapy procedures (26%); more frequent and complex imaging services such as MRI scans and echocardiograms (18%); more laboratory and other tests (11%); and more utilization of prescription drugs in doctors' offices (11%).

Impact of Spending Increases on Part B Premiums.[21] Payments for physicians' services account for close to 40% of Part B costs. Increased spending on physicians' services therefore has a considerable impact on overall Part B costs, and by extension on the amount beneficiaries are required to pay in monthly Part B premiums.

By law, beneficiary premiums equal 25% of Part B program costs. The 2005 premium ($78.20) represented a 17.4% increase over the 2004 premium ($66.60). The 2005 annual Medicare Trustees' report estimated that the 2006 premium would

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[17] (...continued)
in order to keep spending in line with the SGR target. The Consolidated Appropriations Resolution of 2003 (CAR, P.L. 108-7), enacted February 20, 2003, enabled CMS to revise FY1998 and FY1999 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.

[18] MedPAC, Mar. 2005.

[19] CBO, Mar. 2005 baseline.

[20] MedPAC, Mar. 2005.

[21] For a discussion of Part B premiums, see CRS Report RL32582, *Medicare: Part B Premiums*, by Jennifer O'Sullivan.

be $87.70, a 12.1% increase over 2005.[22] However, shortly after issuance of the Trustees' report, CMS modified the estimate based on more recent spending data. The 15% increase for physicians' services in 2004 was expected to result in an additional $1.50 over the amount projected in the Trustees' report;[23] this would mean an estimated premium of $89.20. The final premium amount will not be announced until the fall.

It should be noted that these premium estimates are based on the assumption that the negative update to the conversion factor will occur. If Congress overrides the negative update, this could result in an even higher premium amount. Some observers have suggested that this consideration may make it more difficult to enact an override this year.

Recommendations for Change. While there is general agreement that the SGR system needs to be replaced or modified, a consensus has not developed on a long tem solution. Part of the problem is that any permanent change is very costly. This reflects the fact that the current CBO baseline (based on current law requirements) assumes a reduction in the conversion factor for the next several years. Most observers suggest that it is unlikely that Congress would permit that to happen. However, budget considerations may lead to a shorter-term solution. Several alternative approaches have been suggested.

Replace Formula; Link Updates to Payment Adequacy. MedPAC states that the annual update should not be automatic, but should be linked to a number of factors including beneficiary access to services, the quality of services provided, and appropriateness of cost increases. MedPac noted that it used this approach in making its recommendations for 2006. It noted that beneficiaries access to care, supply of physicians and the ratio of private payment rates to Medicare has remained stable. (See discussions, below). It concluded that current payment rates are adequate and should be updated by the projected change in physicians' costs less an adjustment for productivity growth.

Make Administrative Changes to Current Formula Calculation. While a change in the formula would require legislation, some observers have suggested that there are things CMS could do administratively to ease the impact of the current formula. Proponents argue that these changes could somewhat moderate the negative updates that are predicted. One change which has been suggested for several years is the removal of covered Part B prescription drugs from the SGR baseline (thereby removing this rapidly escalating cost factor from the calculation).

In the November 2004 final fee schedule rule, CMS decided against removing drugs from the calculation. It stated that it was reviewing the issues. It noted that

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[22] Board of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2005 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, communication, Mar. 2005, p. 156.

[23] Letter from Herb B. Kuhn, Director, Center for Medicare Management, CMS, to MedPAC, Mar. 31, 2005.

administrative changes to the SGR would have significant long-term cost implications but would not have an impact on the update for 2006 or the subsequent few years. It also noted that it had taken several actions to improve the payment system in the past several years including: (1) using multifactor productivity in place of labor productivity in the MEI calculation, leading to a higher MEI beginning in 2003; (2) increasing the weight of malpractice costs in the MEI from 3.2% to 3.9%, beginning in 2004; and (3) incorporating increases in malpractice premiums beginning in 2004.

Modify Current Formula. Some persons have recommended modifying the current formula to more closely target the incentives. MedPAC has identified, but not specifically recommended, some possible alternatives to the current nationwide volume target. The intent would be to create smaller groups thereby increasing the likelihood that actions of individual physicians would be influenced by the incentives. Targets could be defined for groups such as multispecialty groups, regions, hospital medical staffs; or specific service categories.

GAO also identified possible modifications to the current system including using actual spending from a new, more recent base year (instead of 1996) for making the SGR calculation; eliminating the cumulative target mechanism and returning to a system of annual targets; and modifying the allowance for volume and intensity growth to more closely reflect technological innovation and changes in medical practice. It further noted that some of these options could be combined.[24]

Incorporate Evidence-Based Medicine; Pay for Performance. A number of observers have expressed concerns about the increases in the volume of services. Some of the increase can be linked to improvements in care, and Medicare's increased emphasis on preventive services. However, some increased service use may be more questionable. Further, there are wide geographic variations in the number and intensity of services provided, even among physicians in the same specialty. Analyses of these geographic variations shows that increased service use does not necessarily translate into increased quality or improved health outcomes.

Some observers have recommended incorporating quality measurements into the payment calculation. Quality measurements would be based on evidence based medicine. Physicians with higher quality performance would be paid more while those with lower quality performance would be paid less. Some have labeled this "pay for performance" (or "P4P").

CMS reports that it is collaborating with a range of public and private stakeholders who have a common goal of improving quality and avoiding unnecessary health care costs.[25] As part of this effort, it is implementing a pay for performance demonstration project (as required by Section 649 of MMA). The legislation requires the project to adopt and use health information technology and evidence-based outcomes measures for: promoting continuity of care; helping

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[24] General Accountability Office, *Medicare Physician Payments: Concerns About Spending Target System Prompt Interest in Considering Reforms*, Oct. 2004.

[25] CMS, *Medicare "Pay for Performance (P4P)" Initiatives*, press release, Jan. 31, 2005.

stabilize medical conditions; preventing or minimizing acute exacerbations of chronic conditions; and reducing adverse health outcomes, such as adverse drug interactions relating to polypharmacy.

MedPAC also recommends approaches that would allow Medicare to differentiate among providers when making payments as a way to reduce inappropriate volume of services and improve quality. It suggests that as a first step, Congress should adopt budget neutral pay for performance programs, starting with a small share of payments. For physicians, the first step would be a set of measures related to the use and functions of information technology.

MedPAC is concerned that the issue of increased volume, particularly for imaging services needs to be addressed. It recommends that Medicare measure resource use and share the results with physicians on a confidential basis; physicians would be able to compare their resource use with that of their peers. It further recommends that providers who perform imaging services and physicians who interpret them be required to meet quality standards as a condition of Medicare payment.[26]

Cost of Reform Options. As noted earlier, any change in the current payment formula which would avert the scheduled negative update would involve considerable costs. A permanent fix would be more costly than a temporary one-year fix. On March 24, 2005, CBO issued its preliminary estimates of various alternatives.[27] For example, providing for a 1.5% increase again in 2006 would increase outlays by $9.7 billion over the 2005-2010 period; freezing rates at the 2005 level (overriding the negative updates each year) would cost $27.1 billion over the period, and providing for an automatic MEI update (and eliminating the SGR) would cost $49.7 billion.

Access to Care

Questions have been raised about beneficiaries continued access to care. In 2002, the year the conversion factor was cut, press reports in many part of the country documented many cases where beneficiaries were unable to find a physician because physicians in their area were refusing to accept new Medicare patients. Despite slight increases in the updates for 2003, 2004, and 2005, some physicians claim that program payments continue to fall significantly short of expenses. They suggest that problems will be magnified if the cuts, anticipated after 2006, are allowed to go into effect. Access to care can be measured by reviewing beneficiary ability to get an appointment with a new physician, the supply of physicians seeing Medicare patients, and physicians' willingness to see new patients.

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[26] Testimony of Glenn Hackbarth, Chairman of MedPAC, before House Ways and Means Committee, Feb. 10, 2005.

[27] [http://www.cbo.gov/ftpdocs/62xx/doc6296/SGRoptions.pdf]

Access. Periodic analyses by PPRC, and subsequently MedPAC, as well as CMS showed that access to physicians' services generally remained good after implementation of the fee schedule.[28]

MedPAC's 2005 report updates the available information.[29] The report reviewed several surveys conducted between 2003 and 2004. Its analysis suggests that overall, beneficiary access to physicians' services tends to be good. A 2004 telephone survey conducted by MedPAC compared access for Medicare beneficiaries with that for privately insured persons age 50 to 64. It noted that for both groups access to physicians was good and for some indicators was slightly better for the Medicare population. The large majority of Medicare beneficiaries (89%)had no problem or only a small problem in getting an appointment with a new primary care physician; 9% reported a big problem and 2% did not respond. Among those with an appointment, 95% never or rarely had to wait longer than they wanted to get an appointment for routine care and 96% never or rarely had to wait for care to treat an illness or injury.

Similar results were obtained from the CMS-sponsored Consumer Assessment of Health Plans Survey for Medicare fee-for-service (CAHPS-FFS). In that survey, almost all (95%) beneficiaries in 2003 reported having small or no problems receiving care they or their doctor thought necessary and 90% were able to schedule an appointment for regular or routine care as soon as they wanted.

The Center for Studying Health Systems Change (HSC) reported that after a significant decline from 1997 to 2001, access to physicians' services had stabilized between 2001 and 2003. About 9.9% of Medicare beneficiaries reported delaying or not getting need care in 2003, compared to 11.0% in 2001. For the privately insured near-elderly population, the rates were 17.4% in 2003 and 18.4% in 2001.

Physician Supply. MedPAC reports that the growth in the number of physicians regularly billing Medicare fee-for-service patients has kept pace with the recent growth in the Medicare population. MedPAC reports that in 2003, 470,213 physicians regularly billed Medicare, accounting for 12.3 physicians per 1,000 Part B Medicare beneficiaries. This represents an increase from the physician population ratio of 11.7 recorded in 1999.

Physicians' Willingness to See New Beneficiaries. A related concern is the possible decline in the percentage of physicians accepting new Medicare patients.[30] However, results from a 2003 survey by the National Ambulatory Medical

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[28] (1) MedPAC, *Medicare Beneficiaries Access to Quality Health Care. Report to Congress: Medicare Payment Policy*, Mar. 2000; and (2) Julie A. Schoenman, Kevin Hayes, and C. Michael Cheng, "Medicare Physician Payment Changes: Impact on Physicians and Beneficiaries," *Health Affairs*, vol. 20, no.2, Mar./Apr. 2001.

[29] MedPAC, Mar. 2005.

[30] For example, a survey by the HSC reported 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 (continued...)

Care Survey (NAMCS) indicate that most physicians with at least 10% of their practice revenue coming from Medicare are willing to see new patients. It reported that 94% accepted some or all new Medicare patients, an increase of one percentage point over 2002.

Pending Study. As noted above, MMA requires GAO to study and report to Congress by June 8, 2005, on beneficiary access to physicians' services. The study is to include (1) an assessment of the use of such services through an analysis of claims data; (2) an examination of changes in the use of physicians' services over time; and (3) an examination of the extent to which physicians are not accepting new Medicare beneficiaries as patients. The report is to include a determination, based on claims data, of potential access problems in certain geographic areas. It is also to include a determination as to whether access has improved, remained constant, or deteriorated over time.

Geographic Variation in Payments

Geographic Practice Cost Indices. Medicare makes a geographic adjustment to each component of the physician fee schedule.[31] 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 in 2002, the small updates in 2003-2005, and the prospects of further reductions in future years.

As noted earlier, MMA made two changes to the geographic adjusters. It raised the geographic adjustment for the work component of the fee schedule to 1.000 in any area where the multiplier would otherwise be less. This provision applies from 2004 through 2006. MMA also raised all three geographic adjusters for Alaska to 1.67. This provision is effective for 2004 and 2005.

Additionally, MMA requires the Secretary to review and consider alternative data sources other than those currently used to establish the geographic index for the practice expense component under the physician fee schedule. The review is to be conducted in two physician payment localities, one of which includes rural areas and one of which is statewide. The Secretary is required to collaborate with state and other organizations representing physicians as well as other persons. The report is due to Congress by January 1, 2006.

State-by-State Variation. 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 variations 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,

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[30] (...continued)
with low Medicare revenues. (Testimony of Paul Ginsburg before the House Committee on Ways and Means, Subcommittee on Health, Feb. 28,2002.)

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

variations in managed care penetration, the extent to which populations obtain services in other states, 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. For these reasons, CMS considers state-by-state Medicare spending data misleading and is therefore no longer publishing this data.

Payment Localities. Geographic adjustments are applied by payment locality. There are currently 89 localities; some are statewide, while others are substate areas. Some observers have recommended that changes be made to the composition of some of the current localities; for example, they state that costs in a particular community significantly exceed those in other parts of the same locality.

CMS states that it is looking at the alternatives but has been unable to come up with a policy and criteria that would satisfactorily apply to all areas. In the November final fee schedule rule, CMS reiterated its policy that it would consider requests for locality changes when there is demonstrated consensus within the state medical association for the change. It should be noted that any changes must be made in a budget-neutral fashion for the state. Thus, if higher geographic practice cost indices (and thus payments) are applied in one part of the state, they must be offset by lower indices (and payments) in other parts of the state.

Medicare Versus Private Payment Rates

Some persons contend that Medicare payments lag behind those in the private sector. MedPAC's 2005 report notes that a contractor to MedPAC found that the difference between Medicare and private rates decreased from the mid-1990s through 2001. In 1994, Medicare's rates were about 66% of private plan rates; the percentage rose to 83% in 2001. Medicare's improved position was largely attributable to shifts in private plan enrollment from higher-paying indemnity plans to lower-paying managed care plans.

The contractor's analysis of 2003 data showed that the gap widened from 2001 to 2002 but showed no change in 2003. Medicare rates reflected the 2002 cut of 5.4% in the conversion factor. On the other hand, from 2002 to 2003 there was a slight shift in private plan enrollment mix to plan types with higher physician fees. The net impact was that the Medicare's rates were about 81% of private plan rates in 2002 and 2003.[32]

Payments for Oncology Services

Background. The level of payments for practice expenses became 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. Medicare also covers certain oral cancer drugs. Covered drugs are

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[32] Medicare Payment Advisory Commission, *Medicare Payment Policy, Report to Congress*, Mar. 2005

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 a physician's professional service.

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

MMA Changes; 2004 Modifications. As noted in the section outlining MMA provisions, MMA specifically addressed this issue. It provided for an increase in practice expense payments, based on a survey of costs conducted by the American Society of Clinical Oncologists (ASCO). It also established a work relative value for drug administration services. At the same time, the law revised the methodology used to calculate payments for covered drugs. A modified version of the average wholesale price (AWP) methodology was used in 2004. Beginning in 2005, drugs are paid using the average sales price (ASP) methodology. Drug payments are less under the new system. A transitional payment was authorized in 2004 and 2005 to ease the adjustment to the new system. CMS estimates that for 2004 the increases on the practice expense side balanced the reductions on the drug side.

2005 Modifications. Many observers suggested that changes to the drug payment methodology were long overdue and that reductions were in order given the previous overpayments. However, many oncologists have stated that the revised payment methodologies, particularly the changes for drug payments that were implemented in 2005, will lead to a net loss in Medicare payments.

CMS took a number of actions designed to respond to the oncologists' concerns. On November 1, 2004, it announced a national oncology one-year demonstration project focusing on three areas of concern for cancer patients: pain, nausea and vomiting, and fatigue. Practitioners participating in the demonstration must provide information (using new temporary billing codes) to describe a chemotherapy patient's status with respect to these three areas. Any oncologist can participate in the demonstration; those that do will receive $130 per patient per day. CMS estimated that this demonstration will increase payments in 2005 by about $300 million.

Also on November 1, 2004, CMS also announced coverage for certain colorectal cancer drugs being used "off label" in nine clinical trials sponsored in part by the National Cancer Institute. In addition, it announced expanded coverage for positron emission tomography (PET) scans for cervical cancer and for studies of PET for diagnosis and staging involving a broad range of additional types of cancer.

On November 15, 2004, CMS issued the 2005 physician fee schedule.[33] This regulation contained a number of modifications in coding and payment for drug administration services that allow for higher payments for a number of these services. The AMA's Current Procedural Terminology Editorial Panel developed 18 new codes; and the AMA's RUC recommended the associated relative values to be used for billing purposes. CMS adopted these codes and values for use beginning in 2005.[34] The new codes include payments for associated staff time to prepare pharmaceuticals and physician work for supervising pharmaceutical preparation. In addition, physicians will now be allowed to receive additional payments when a second drug is infused.

CMS estimated that drug administration payments represent about 28% of oncologist revenues. It estimated that all changes taken together will increase payments for these services by roughly 10% from 2004 to 2005. This includes an increase of 5% for coding and relative value changes, a 12% reduction for the reduction in the transition adjustment (from a 32% to a 3% add-on), a 3% increase attributable to increased payments for injections, the 1.5% mandatory increase in the 2005 update, and a 15% increase for the one-year demonstration project.

The 10% increase for drug administration services will be offset by a reduction of 13% in drug revenues (which account for 69% of oncologists' total revenues). The net impact is a reduction of 6% from 2004 to 2005, assuming constant utilization. However, CMS, using historical trends in volume, assumed an increase in utilization, thereby increasing revenues by 8%.

On December 1, 2004, the Government Accountability Office (GAO) issued a report on Medicare payments to oncologists.[35] This report estimated that payments for drug administration services would be 130% higher in 2005 than they were in 2003, assuming no changes in utilization. Payments for drugs would decline over the period; however, the GAO expected these payments to exceed acquisition costs by 22% in 2004 and by 6% in 2005. It should be noted that the estimates for administration services did not include the impact of coding changes announced in the final fee schedule or the one-year demonstration project, both of which will further increase payments.

Some oncologists continue to express concerns about payment levels and, by extension, access. CMS, in the preamble to the 2005 fee schedule regulations, noted that it planed to continue to monitor any shifts or changes in utilization patterns. It should also be noted that MMA required MedPAC to review payment changes made by Section 303 of MMA with an emphasis on quality, beneficiary satisfaction,

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[33] Centers for Medicare and Medicaid Services, "Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2005; Final Rule," 69 *Federal Register* 66235, Nov. 15, 2004.

[34] Because permanent codes will not be includes in the CPT book until 2006, CMS is allowing the use of temporary ("G codes") for use in 2005.

[35] U.S. Government Accountability Office, *Medicare Chemotherapy Payments: New Drug and Administration Fees Are Closer to Provider's Costs*, letter to Hon. Joe Barton, Chairman of the House Committee on Energy and Commerce, GAO-05-142R, Dec. 1, 2004.

adequacy of reimbursement, and impact on physician practices. The study is due January 1, 2006.

For a further discussion of this issue, see CRS Report RL31419, *Medicare: Payments for Covered Part B Prescription Drugs*.

Documentation for Evaluation and Management Services

Approximately 40% of Medicare payments for physicians' 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 2003 report estimated that there were $13.3 billion in improper payments in FY2002 (6.3% of total fee-for-service spending); of this amount 28.6% was attributed to documentation problems.[36]

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 clinical examples illustrating the guidelines. This process continued to prove controversial with many physicians arguing that the guidelines continued to be

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[36] U.S. Department of Health and Human Services, Office of the Inspector General, *Improper Fiscal Year 2002 Medicare Fee-for-Service Payments*, Report A-17-02-02202, Jan. 8, 2003.

unworkable. In response to the continuing concerns, on July 19, 2001, Secretary Thompson announced that HHS would step back and reexamine the whole issue.[37]

MMA prohibits the Secretary from implementing any new documentation guidelines for, or clinical examples of, E&M services unless the Secretary has: (1) developed the guidelines in collaboration with practicing physicians (both generalists and specialists) and provided for an assessment by the physician community; (2) established a plan containing specific goals for improving the use of guidelines; (3) conducted representative pilot projects to test the guidelines; (4) found the guidelines meet established objectives; and (5) established and implemented an education program on the use of the guidelines with appropriate outreach. MMA further specifies that the goals of the guidelines are to identify clinically relevant documentation needed for coding purposes; decrease the level of non-clinically pertinent and burdensome documentation time and content in the physician's medical records, increase accuracy by reviewers, and educate both physicians and reviewers. The Secretary is also required to study the development of a simpler alternative system of documentation for physician claims.

Concierge Care

In the past couple of years, some physicians have altered their relationship with their patients. Some doctors, in return for additional charges, offer their patients additional services such as round the clock access to physicians, same-day appointments, comprehensive care, additional preventive services, and more time spent with individual patients. In return, patients are required to pay a fee or retainer which can range from $500 to $1,500 per year. This practice has been labeled "concierge care." Patients who do not pay the additional charges typically have to find another doctor.

Some physicians see concierge care as a way of permitting them to spend more time with individual patients as well as a way to increase their income. However, questions have been raised regarding the implications of concierge care for patients, particularly Medicare beneficiaries. One concern is that while wealthier patients might be able to afford the additional costs, other patients might find it more difficult to gain access to needed services.

The Office of Inspector General (OIG) issued an OIG Alert on March 31, 2004. The Alert reminded Medicare participating physicians about the potential liabilities posed by billing for services already covered by Medicare. Participating physicians can bill their patients for the requisite coinsurance and deductibles as well as for uncovered services. However, the Alert noted that it had been brought to the OIG's attention that some concierge contract services, while described as uncovered services, were actually services covered by Medicare. This would be in violation of the physician's assignment agreement and could subject the physician to civil monetary penalties.

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[37] Testimony of Secretary of Health and Human Services Tommy G. Thompson, in U.S. Congress, House Committee on Ways and Means, *Administration's Principles to Strengthen and Modernize Medicare*, July 19, 2001.

Prospects

Under current law, the application of the SGR system will result in negative annual updates in physician payments beginning in 2006. Many expect that Congress will address this issue in 2005. As of this writing, it is not clear what approach Congress will take. MMA left the SGR system in place but overrode its application for 2004 and 2005. Congress could take this approach again. Alternatively, it could choose to make longer-term changes by modifying or replacing the SGR system.

Appendix A. MMA Provisions Relating to Physicians

Fee Schedule Modifications

MMA made several changes in the calculation of the fee schedule. Over the short term, generally 2004-2005, these are designed to increase program payments to physicians. They do not however, address the underlying problems with the formula used to calculate program payments under the fee schedule.

- The update to the conversion factor can be no less than 1.5% in 2004 and 2005 (Section 601(a) of MMA).
- The formula for calculating the sustainable growth rate (SGR) is modified by replacing the existing GDP factor (which measured a one year change from the preceding year) to a 10-year rolling average (Section 601(b) of MMA).
- The geographic index adjustments in Alaska for the work component, practice expense component and malpractice component are each raised to 1.67 for 2004 and 2005. This results in an increase in payments to Alaska physicians in these years. (Section 602 of MMA).
- There is a floor of 1.00 on the work adjustment for the 2004-2006 period. (Section 412 of MMA).
- An additional 5% in payments is provided for certain physicians in scarcity areas for the period January 1, 2005 through December 31, 2007. The Secretary is required to identify those areas with the lowest ratios of physicians to beneficiaries, which collectively represent 20% of the total Medicare beneficiary population in those areas. The list of counties will be revised no less often than once every three years unless there are no new data. (Section 413 of MMA).

The following table summarizes CBO's estimates of the impact of these provisions, excluding those with no costs or costs below the threshold.

Table 3. Changes in Direct Spending Attributable to Selected Physician-Related Provisions

(in billions)

Provision		Spending increases	
Topic	**Section**	**FY2004-FY2008**	**FY2004-FY2013**
Update revisions	601	$2.4	$0.2
Alaska	602	$0.1	$0.1
Floor on work component	412	$1.0	$1.0
Bonus payments	413	$0.7	$0.7

Drug Administration Services

MMA revises the way covered Part B drugs are paid under the program; this has the effect of lowering program payments for the actual drugs. At the same time, MMA increases the payments associated with drug administration services. These provisions affect selected specialties, primarily oncologists.

The following highlight the MMA changes made in payments for drug administration services. Many of the provisions are very technical; in general they result in higher payments. The net impact is an overall increase in payments. (Section 303(a) of MMA). The MMA changes in the payment methodology for covered Part B drugs is contained in a companion CRS report.[38]

- Beginning in 2004, the practice expense relative value units for oncology services are to be adjusted using survey data that was submitted to the Secretary by January 1, 2003. (This data which was submitted by the American Society of Clinical Oncologists (ASCO) showed higher costs than previously assumed by CMS in its calculations.) The additional expenditures are exempt from the budget neutrality adjustment for 2004.
- Beginning in 2004, the work relative value units for drug administration services are equal to the work relative value units for a level one office medical visit for an established patient. Drug administration services are defined as those classified as of October 1, 2003, within the following groups of procedures but for which no work relative value unit had been assigned: therapeutic or diagnostic infusions (excluding chemotherapy); chemotherapy administration services; and therapeutic, prophylactic, or diagnostic injections. This results in an increase in payments, since these services previously had no work relative value units assigned.
- In 2005 and 2006, the practice relative value units for other drug administration services will be increased using appropriate supplemental survey data submitted by March 1, 2004 for 2005 and March 1, 2005, for 2006. Data is to be accepted only for those specialties that received 40% or more of their Medicare payments from drugs and biologicals in 2002, and would not apply to the ASCO survey submitted by January 1, 2003. The additional expenditures are exempt from the budget neutrality adjustment for 2005 and 2006.
- The Secretary is required to promptly evaluate drug administration codes to ensure accurate reporting and billing. The codes will be evaluated under existing processes and in consultation with interested parties. The additional expenditures are exempt from the budget neutrality adjustment for 2005 and 2006.

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[38] CRS Report RL31419, *Medicare: Payments for Covered Part B Drugs*, by Jennifer O'Sullivan.

- Other services paid under the nonphysician work pool methodology (applicable to services for which no work relative values have been assigned) will be unchanged by the MMA changes.
- Medicare's payment policy, in effect on October 1, 2003, for the administration of more than one drug or biological through the push technique is to be reviewed. Any resulting modification is exempt from the budget neutrality requirement in 2004.[39]
- The drug administration payments otherwise calculated are to be increased by 32% in 2004 and 3% in 2005. This is labeled a transitional adjustment and is intended to offset the effects of the reduction in payments for covered Part B drugs.
- The Secretary is prohibited from making payment adjustments for drugs in 2004, unless a concurrent adjustment is made in the calculation of practice expenses as required by Section 303(a). (Section 303(f) of MMA).

It should be noted that Section 303(j) of MMA limits the application of Section 303 to the specialties of hematology, hematology/oncology and medical oncology. Section 304 of MMA specifies that the provisions of Section 303 apply to other specialties. As noted in the conference report on the bill, this allowed CBO to provide one estimate for the impact of the provisions on oncologists and another estimate for the impact on other specialties.

CBO estimated that for oncologists under Section 303, the net impact of the revisions in the payment for drugs coupled with the increases in payments for the administration of drugs was a savings of $0.9 billion over the 2004-2008 period and $4.2 billion over the 2004-2013 period. For other specialties, the savings under Section 304 totaled $2.2 billion over the 2004-2008 period and $7.3 billion over the 2004-2013 period.

Studies and Reports

MMA requires the following studies and reports relating to physicians' services.

- MedPAC is required to review the payment changes made under Section 303 (drug administration and payment) and report to Congress by January 1, 2006, on: the quality of care furnished to individuals; their satisfaction with care; the adequacy of reimbursement taking into account geographic variation and practice size; and the impact on physician practices. MedPAC is required to conduct a similar study for drug administration services furnished by other specialties; the report is due January 1, 2007. (Section 303(a) of MMA).
- GAO is required to study and submit a report to Congress by June 8, 2005, on beneficiary access to physicians' services, including changes in such access over time (Section 604 of MMA).

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[39] CMS modified the policy, effective January 1, 2004, to allow for the billing for drug administration through the push technique once per day for each drug administered.

- The Secretary is required to review and consider alternative data sources other than those currently used to establish the geographic index for the practice expense component under the physician fee schedule. The report is due to Congress by January 1, 2006. (Section 605 of MMA)
- MedPAC is required to submit a report to Congress by December 8, 2004, on the effects of the refinements to the practice expense component after transition to the full resource-based system in 2002. Also by December 8, 2004, MedPAC is required to submit a report to Congress on the extent to which increases in the volume of services under Part B are the result of care that improves the health and well-being of beneficiaries. (Section 606 of MMA)
- MedPac is required to study and report to Congress by January 1, 2005 on the feasibility and advisability of paying for surgical first assisting services furnished by a certified registered first nurse assistant under Part B. (Section 643 of MMA)
- MedPAC is required to study and report to Congress by January 1, 2005, on the practice expense relative values for cardio-thoracic surgeons to determine if the values adequately take into account the attendant costs such physicians incur in providing clinical staff for patient care in hospitals. (Section 644 of MMA)
- The GAO is required to study and report to Congress by December 8, 2004, on the propagation of concierge care and its impact on beneficiaries. (See *Issues* section.) (Section 650 of MMA)

Other

MMA includes a number of additional provisions relating to physicians' services including:

- Podiatrists, dentists, and optometrists are permitted to enter into private contracting arrangements. (Section 603 of MMA)
- Medicare payments may be made to an entity which has a contractual relationship with the physician or other entity (namely a staffing entity). The entity and the contractual arrangement will have to meet program integrity and other standards specified by the Secretary. (Section 952 of MMA)
- The Secretary is required to use a consultative process prior to implementing any new documentation guidelines for evaluation and management (i.e., visit) services. (See *Issues* section) (Section 941 of MMA)
- MMA contains a number of additional provisions designed to address physicians' concerns with regulatory burdens. (Title IX of MMA)

Appendix B. 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 three years and phased-in over two 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.[40]

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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[40] Physician Payment Review Commission, *Annual Report to Congress, 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.... [41]

The 1989 budget 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.

The recently enacted MMA contained several provisions relating to the geographic calculations. The law sets a floor of 1.0 on the work adjustment for the 2004-2006 period. It also raises the adjustments in Alaska for the work component, practice expense component, and malpractice component to 1.67 for the 2004-2006 period.

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

Calculation[42]

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 five 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 five 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.[43] 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.

It was expected that the 2004 update would reflect the 2000 census data. However, CMS stated that the work and practice expense adjustments relied on

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[42] 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," 65 *Federal Register* 44189, July 17, 2000; and (2) "Medicare Program; Revisions to Payment Polices Under the Physician Fee Schedule for Calendar Year 2001; Final Rule," 65 *Federal Register* 65404, Nov. 1, 2000.

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

special tabulations which had not been completed in time for use in the 2004 fee schedule. The 2000 data will be used for 2005 through 2007. The same data sources and methodology used for the development of the 2001-2003 period were used for the subsequent period.

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. As is the case for calculating the work indices, the 2000 census is used for 2005 through 2007.

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. HUD publishes the data on a metropolitan area basis. The 2005-2007 indices are based on FY2004 FMR data.

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.

MMA requires the Secretary to review and consider alternative data sources, other than those currently used, to establish the geographic index for the practice expense component. The report is due to Congress by January 1, 2006.

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 three-years of data is used to smooth out year-to-year fluctuations. Premiums data for 1996-1998 was used for the 2001-2003 indices.

Only the geographic index for malpractice was adjusted for 2004. Half of the change was implemented in 2004; the other half is to be implemented in 2005. CMS indicates that it may make additional changes upon receipt of more recent data.

Appendix C. Development of Practice Expense Payment Methodology

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 nurses and other nonphysician 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 (now CMS) 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-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, was labeled the "top down" approach. For each medical specialty, HCFA estimated 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) were 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.[44]

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.

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.[45] The final rule

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

[45] U.S. Department of Health and Human Services, 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*

(continued...)

issued December 31, 2002 for 2003 accepted supplemental survey data from physical therapists.

MMA required CMS to use, beginning January 1, 2004, survey data submitted by January 1, 2003 on practice expenses for oncology drug administration services. In effect, this required the use of data submitted by the American Society of Clinical Oncology. The revised 2004 fee schedule regulation, issued January 7, 2004, provides for the use of this data.

Other Activities. CMS refines practice expense relative value units on an ongoing basis. Assisting in this process is a multispecialty subcommittee of the AMA's RUC. This subcommittee, the Practice Expense Advisory Committee (PEAC), reviews 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.

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[45] (...continued)
Year 2002; Final Rule, 66 *Federal Register* 55245, Nov. 1, 2001.

Appendix D. Private Contracting Rules

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 private contract with a Medicare patient, that physician must agree to forego any reimbursement by Medicare for all Medicare beneficiaries for two years. The patient is not subject to the two-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 doctors of medicine and osteopathy. (BBA 97 did not include chiropractors, podiatrists, dentists, and optometrists. MMA includes these limited license practitioners, except for chiropractors who remain unable to enter into private contracts) 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 two 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 Advantage*; (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 Advantage and Private Contracting*. A private contracting physician may not receive payments from a Medicare Advantage *(formerly 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.

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 two-year exclusion proved very controversial. Proponents of private contracting viewed the two-year exclusion as a disincentive to enter these arrangements. They argued that physicians should not be excluded entirely from Medicare because of their decision to contract in an individual case. Other observers were concerned that removal of the two-year limit would place beneficiaries at risk. They contended 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 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 two-year exclusion. However, the provision has not been amended or repealed, except for the MMA provision allowing podiatrists, dentists, and optometrists to private contract