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Medicare: Payments to Physicians

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Medicare: Payments to Physicians

Summary

Medicare law specifies a formula for calculating the annual update in payments for physicians' services. The formula resulted in an actual negative update in payments per service for 2002. Additional reductions were slated to go into effect again beginning in 2003; however, congressional action has prevented these reductions for 2003-2009. Many Members have been concerned about the impact of potential 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 were estimated at $56.4 billion in FY2008 (about 12.5% of total benefit payments, including those made under the new prescription drug program). 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 2008 is $38.0870, 0.5% above the 2007 level.

The fee schedule places a limit on payment per service but not on the 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 subsequent years. However, several times legislation has prevented this from occurring — most recently through 2009.

By law, the conversion factor was slated to be cut 10.6% on July 1, 2008. However, on July 15, 2008, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) became law (P.L.110-275). This law freezes physician fees at the June 2008 level until January 2009. In January 2009, the fees will increase by 1.1%. This report will be updated as events warrant.

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Introduction: The Medicare Fee Schedule

Medicare is a nationwide program which offers health insurance protection for 43 million aged and disabled persons. Currently, 80% 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 20% of beneficiaries are enrolled in managed care organizations, under the Medicare Advantage 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 $56.4 billion in FY2008 (12.5% of total Medicare benefits.)[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 (calculated using 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; each of these years saw a slight increase. The Deficit Reduction Act of 2005 (DRA, P.L. 109-171, enacted February 8, 2006) froze the 2006 conversion factor at the 2005 level. The Tax Relief and Health Care Act of 2006 (TRHCA, P.L. 109-432, enacted December 20, 2006) froze the 2007 conversion factor at the same level for an additional year. Further, for the six-month period beginning July 1, 2007, physicians who voluntarily reported certain quality measures could receive bonus payments of 1.5%. The Medicare, Medicaid, and

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[1] Congressional Budget Office, March 2008 baseline. Note that these figures do not include spending by managed care plans for physicians' services; such plans are paid on a capitated basis for all services provided to Medicare beneficiaries. The physician spending figure reflects the statutory reduction in the conversion factor beginning July 1, 2008, as discussed in subsequent sections of this report.

SCHIP Extension Act of 2007 (MMSEA, P.L. 110-173, enacted December 29, 2007) provided for a 0.5% increase for the six-month period beginning January 1, 2008. It also extended the quality reporting program though 2009.

By law, the conversion factor was slated to be cut 10.6% on July 1, 2008. However, on July 15, 2008, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) became law (P.L.110-275). This law freezes physician fees at the June 2008 level until January 2009. In January 2009, the fees will increase by 1.1%. In 2010, fees will revert back to current law levels, resulting in a 21% reduction to Medicare physician fee levels, according to CBO.[2]

On June 27, 2008, prior to passage of MIPPA, the Centers for Medicare and Medicaid Services (CMS) announced plans to instruct its contractors not to process any physician and non-physician practitioner claims for the first 10 business days of July. According to existing law, electronic claims are not to be paid any sooner than 14 days (29 days for paper claims) and not later than the 30th day they are submitted (otherwise, CMS must pay interest on those claims). CMS stated that by holding claims for services that were delivered on or after July 1, it would not be making any payments on the 10.6% reduction until July 15, at the earliest. It was hoped that prior to that date, Congress would be able to take final action on a measure addressing the physician payment issue. On July 18, 2008, after enactment of MIPPA, CMS notified payment contractors that the fee levels should be corrected within 10 business days; any claims processed at the lower levels would automatically be reprocessed. CMS also notified physicians and other practitioners that they can waive retroactive higher beneficiary cost-sharing amounts that would have applied if the claims had been processed at the higher payment levels.

MIPPA also extends the quality reporting program through 2010, establishes a physician feedback program to provide confidential reports to physicians, and establishes incentives for electronic prescribing in the Medicare program.[3]

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

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[2] The CBO cost estimate is available at [http://www.cbo.gov/ftpdocs/95xx/doc9595/hr6331pgo.pdf].

[3] For a summary of MIPPA, see CRS Report RL34592, *P.L. 110-275: The Medicare Improvements for Patients and Providers Act of 2008*, by Hinda Chaikind et al.

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 the 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[4]); 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 practice cost index (GPCI) adjustment is made to each of the three components of the relative value unit, namely a work adjustment, a practice expense adjustment, and a

[4] The lower facility-based payment reflects the fact that the facility itself receives a separate payment for its costs of providing the service, while the non-facility-based payment to the physician encompasses all practice costs.

malpractice adjustment.[5] These are added together to produce an indexed relative value unit for the service for the locality.[6] 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.[7]

The conversion factor for 2008 is $38.0870. Thus, the payment for a service with an adjusted relative value of 2.3 is $87.60.[8] Anesthesiologists are paid under a separate fee schedule, which uses base and time units; a separate conversion factor ($17.8482 for 2008) applies.

Bonus Payments — Services in Any Rural or Urban Health Professional Shortage Area (HPSA). Physicians who provide covered services in any rural or urban 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

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[5] The law requires the publication of a Geographic Adjustment Factor (GAF) for each payment locality. The GAF is not actually used in the payment formula. It does, however, present the weighted average impact for the locality of the three locality GPCIs (namely work GPCI, practice expense GPCI, and malpractice expense GPCI). 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 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. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173) placed a floor of 1.00 on the work adjustment for the 2004-2006 period; the Tax Relief and Health Care Act of 2006 (P.L. 109-432) extended the provision through 2007. MMSEA extended the provision through June 2008. MIPPA extends it through 2009. Areas that would otherwise have a value below 1.0 (primarily rural areas) receive higher payments over the period.

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

[7] 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.

[8] 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 was implemented through an adjustment to the conversion factor. However, beginning in 2007, it has been implemented through an adjustment to work relative values. MIPPA requires that it again be implemented through the conversion factor beginning in 2009. (See **Appendix A**.)

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) required 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.[9]

Quality Reporting. TRHCA provided that, for the six-month period beginning July 1, 2007, physicians who voluntarily reported certain quality measures could receive a bonus payment of 1.5%; a single consolidated payment would be made in 2008. MMSEA extended the bonus payments for quality reporting occurring in 2008 with the payment for 2008 to be made in 2009. MIPPA extends the quality reporting provision through 2010.

Publication of Fee Schedule. Medicare is administered by the Centers for Medicare and Medicaid Services (CMS). 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 final fee schedule for 2008 was announced November 1, 2007, and published in the *Federal Register* on November 27, 2007.[10] With the exception of the conversion factor, which was subsequently modified by MMSEA (and later, MIPPA), other changes incorporated in the regulation remain in place for 2008. This includes changes in relative values and the continued phase-in of a new methodology for calculating practice expenses.

Beneficiary Protections; Participation Agreements

Medicare pays 80% of the fee schedule amount for physicians' services after beneficiaries have met the annual Part B deductible ($135 in 2008). Beneficiaries are responsible for the remaining 20%, known as coinsurance. A physician may choose whether to accept **assignment** on a claim.[11] 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

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[9] MMA provided for an additional 5% in payments for certain physicians in scarcity areas for the period January 1, 2005, through December 31, 2007. MMSEA extended the provision through June 30, 2008. The provision no longer applies.

[10] 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*, etc; Final Rule, 72 *Federal Register* 66222, November 27, 2007.

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

not agree to accept assignment on *all* Medicare claims in a given year are referred to as **nonparticipating physicians**. It should be noted that the term "nonparticipating physician" does not mean that the physician doesn't deal with Medicare. Nonparticipating physicians 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. Generally, physicians are required to make any changes in their participation status prior to the beginning of the calendar year.

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 2007, 93.3% of physicians (and limited licensed practitioners) billing Medicare were participating physicians. Approximately 99.4% of Medicare-allowed charges for physicians' services were assigned in 2006.[12]

[12] MedPAC, *Medicare Payment Policy*, Report to the Congress, March 2008. (Hereafter cited as MedPAC, March 2008.)

Table 1. Medicare and Physicians

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

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.

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 E**). 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%.[13] The law provides for refinements in relative value units.

The work relative value units incorporated in the initial fee schedule were developed after extensive input from the physician community. Refinements in existing values and establishment of values for new services have been included in the annual fee schedule updates. This refinement and update process is based in part on recommendations made by the American Medical Association's Specialty Society Relative Value Update Committee (RUC) which receives input from 100 specialty societies. The law requires a review every 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. The 2007 fee schedule reflected the results of the third 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. The 2007 fee schedule adopted a new methodology for determining practice expenses; this change is being phased-in over four years. (See **Appendix D**.)

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[13] MedPAC, March 2008.

BBA 97 also directed CMS to develop and implement a resource-based methodology for the malpractice expense component. CMS 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.

Sustainable Growth Rate (SGR) System

The conversion factor is a dollar figure that is the same for all services. It is updated each year according to a complicated formula specified in law. Application of the formula would have resulted in a reduction in the conversion factor for several years. Most recently, Congress overrode the formula through 2009. However, the statutory formula remains in place.

The final physician fee schedule for 2008 (issued before enactment of MMSEA) shows how the update calculation was to be made for 2008. The following discussion provides an overview of this calculation. (For more detail, see **Appendix A**.)

The statutory formula is based on the sustainable growth rate (SGR) system. The SGR system was established because of the concern that the fee schedule itself would not adequately constrain overall 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 glide path 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.

Conversion Factor Calculation

The annual update to the conversion factor calculation is based on the following measures:

- *Medicare Economic Index (MEI)* — measures the weighted average annual price changes in the inputs needed to produce services.

- *Update Adjustment Factor* — used to make actual expenditures and target (allowed) expenditures equal.

- *Allowed expenditures* = actual expenditures updated by the *SGR*.

Under the formula, if expenditures are in line with the target, the update equals the MEI. That is, payments would increase for all services at a rate equal to the changes in input prices. However, in recent years, expenditures have been significantly above the target; therefore, using the defined statutory update would have resulted in an update below the MEI. The higher expenditures reflect a number

of factors, chief of which is that volume and intensity of services are growing at a rate much faster than allowed under the formula.

Update Adjustment Factor

The update 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 adjustment factor is the sum of (1) the *prior year adjustment component*; and (2) the *cumulative adjustment component*. 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 UAF adjustment has been minus 7% for the last several years.

Recent Experience. **Table 2** shows the annual and cumulative allowed expenditures for calendar year 2007. These are the expenditures that, in the absence of MMSEA, would have been used to calculate the update for 2008 (see **Appendix A**). As can be seen from the table, there is a significant difference between the targets and actual spending, both in cumulative spending and annual spending. Under the formula, the UAF would have been minus 26.7% for 2008; however, the formula limited the reduction to minus 7%.

The caps on the adjustment limit the annual reduction or increase. This means that the gap between cumulative actual spending and cumulative allowed spending grows larger each year. This effect is further magnified by the fact that when Congress has overridden the reduction, it has not raised the targets.

Table 2. Annual and Cumulative Allowed and Actual Expenditures for Physicians Services, 2007
(in billions)

Annual allowed expenditures	$83.9
Annual actual expenditures	94.6
Cumulative allowed expenditures	776.6
Cumulative actual expenditures	828.8

Source: U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), *Medicare Program; Revision to Payment Policies Under the Physician Fee Schedule, etc*; Final Rule, 72 *Federal Register* 66377, November 27, 2007.

Sustainable Growth Rate (SGR)

The SGR sets both the cumulative and allowed expenditures under the UAF formula. The SGR is based on the best data available in September of each year. It is estimated and revised twice, with appropriate changes made to allowable expenditures. The November 2007 rule included the preliminary 2008 SGR, a revised 2007 SGR, and the final revision to the 2006 SGR.

The SGR is the product of

- estimated percentage changes in physicians fees,
- estimated percentage changes in the number of fee-for-service beneficiaries,
- estimated percentage growth in real gross domestic product (GDP) per capita (10-year moving average), and
- estimated percentage changes resulting from changes in laws and regulations.

Table 3 shows the SGR calculations as announced in the November 2007 fee schedule regulation.

Table 3. SGR Calculations

Factors	Preliminary 2008	Revised 2007	Final 2006
Fees	1.9% (1.019)	1.9% (1.019)	2.1% (1.021)
Fee-For-Service Enrollment	-0.7% (0.993)	-2.6% (0.974)	-2.6% (0.974)
Real Per Capita GDP	1.7% (1.017)	1.9% (1.019)	2.1% (1.021)
Law and Regulations	-2.9% (0.971)	2.0% (1.020)	0.0% (1.000)
Total	-0.1% (0.999)	3.2% (1.032)	1.5% (1.015)

Source: 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, etc*; Final Rule, 72 *Federal Register* 66379, November 27, 2007.

Note: Factors (numbers in parentheses) are multiplied to produce totals; totals may not add due to rounding.

Table 3 highlights a couple of items. First, the move from fee-for-service enrollment to managed care enrollment results in a slightly lower SGR. Second, the GDP is a measure of growth in the overall economy. The GDP measure was selected, based on budgetary considerations, namely the underlying idea that sustainable growth should be equivalent to growth in the economy.

Major Changes in Update Calculation

When the fee schedule was first implemented in 1992, the Medicare Volume Performance Standard (MVPS) served as the expenditure target mechanism. Under the MVPS, there was no cumulative goal. Rather, an annual target for physicians services was established. Further, two and then three conversion factors were used (surgical, primary care, and other nonsurgical). The Balanced Budget Act of 1997 (BBA97, P.L. 105-33) replaced the MVPS with the SGR. 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. However, the estimated $828.8 billion in actual spending from April 1, 1996, through December 31, 2007, far exceeds the cumulative $776.6 billion in allowed expenditures over the period. Under the current system, it would be very difficult to bring spending in below the cumulative target.

BBA 97 also incorporated the GDP into the SGR calculation and provided for the use of a single conversion factor instead of three. The Balanced Budget Refinement Act of 1999 (BBRA 99, P.L. 106-113) incorporated an adjustment for the prior year into the UAF update calculation; it also moved from a fiscal year to a calendar year system.

Recent Updates. The following outlines the update calculations, beginning in 2002.[14]

- *2002 Update*. The formula reduction of 5.4% went into effect.
- *2003 Update*. The December 2002 fee schedule regulation would have set the 2003 update at a negative 4.4%. Subsequently, Congress enacted the Consolidated Appropriations Resolution of 2003 (CAR), which included provisions allowing some technical recalculations. As a result of the CAR provision, the update for 2003 was 1.6%. It was effective March 1, 2003.
- *2004 Update*. The November fee schedule regulation set the update at minus 4.5%. However, MMA set the minimum update at 1.5% for 2004 and 2005.
- *2005 Update*. The MMA provision applied with the update set at 1.5%. In the absence of the MMA provision the update would have been minus 3.3%.
- *2006 Update*. The fee schedule regulation set the update at minus 4.4%. However, the Deficit Reduction Act (DRA, P.L. 109-171) froze the conversion factor at the 2005 level.
- *2007 Update*. The 2007 update would have been minus 5%. However, TRHCA froze the conversion factor for an additional year. In addition, a physician who voluntarily reported on certain quality measures for the period July 1, 2007-December 31, 2007, is eligible for a bonus payment of 1.5% in 2008.

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[14] Note that in certain cases the announced conversion factor reduction reflected both the negative update as well as some other adjustments.

- *January-June 2008 Update*. The 2008 update would have been minus 10.1%. However, MMSEA provided for a 0.5% increase for January-June 2008. It further provided that a physician who voluntarily reports on certain quality measures during 2008 is eligible for a bonus payment of 1.5% in 2009.
- *July-December 2008 Update*. On July 1, 2008, the conversion factor was slated to revert to the level that would have otherwise applied on January 1, 2008, except for the enactment of MMSEA (namely a 10.1% reduction from the 2007 level and a 10.6% reduction from the June 2008 level). MIPPA keeps the July-December 2008 conversion factor at the June 2008 level.
- *2009 Update*. MIPPA specifies that the update for 2009 is 1.1%.

Table 4 shows the recent conversion factors.

Table 4. Conversion Factors, 2000-2008

2000	$36.6137
2001	38.2581
2002	36.1992
2003[a]	36.7856
2004	37.3374
2005	37.8975
2006	37.8975
2007	37.8975
2008	38.0870

Sources: CMS, Annual Fee Schedule Updates.
a. Effective March 1, 2003.

MMA set a floor on the work geographic adjustment level at 1.0 for 2004-2006, thereby slightly increasing the payment amounts in some areas. TRHCA extended the provision through 2007; MMSEA extended it through June 30, 2008. MIPPA extends it through December 2009. In addition, beginning January 1,2009, it raises the work geographic adjustment in Alaska to 1.5 if the index would otherwise be less than 1.5

Other Considerations. Several other significant changes incorporated in the 2008 fee schedule regulation have an impact on individual physician payments. These include any changes in work relative values, the second year of a four-year phase-in of a revised methodology for calculating practice expenses, and DRA mandated changes for payments for imaging services. The net impact of these changes for an individual physician vary by the types and mix of services provided.

Criticisms of Current System

Most observers state that the SGR should either be revised or replaced. They note that in the absence of legislation, negative updates will occur for the foreseeable future. This reflects the fact that volume and intensity are growing at more than double the rate allowed under the SGR system.[15] Further, while legislation has averted recent cuts, the targets have not been raised accordingly.

Many observers contend that the current SGR system has additional flaws. They note that the target is a nationwide aggregate. Thus there is no direct link between individual physician behavior and the targets. An individual physician who reduces volume does not see a proportional increase in payments. A related concern is that there is no distinction between appropriate volume increases and inappropriate volume increases. Another concern is that the targets may not adequately reflect scientific and technological innovations or site-of-service shifts.

Some persons state that actual increases in practice costs are in excess of those allowed under the system. Other observers suggest that the impact of legislative and regulatory changes may not be fully reflected in the SGR calculation. In addition, some persons have stated that Part B drug spending should be excluded from the calculation. However, CMS has consistently stated that it cannot make this change retrospectively without legislation and that, even if it could, it would not yield a positive update for the next several years.

A number of observers have expressed concerns regarding the implications of continuing to use the current system. They state that over time, physicians may be unable to absorb cuts if their marginal costs exceed the updates. They may respond by refusing to see all Medicare patients or new Medicare patients. Quality of care and patient access may be adversely affected. However, some suggest that physicians might respond by becoming more efficient. There is also the concern that patients may be forced to seek care in more costly settings.

Suggested Modifications

While there is general agreement that the SGR system needs to be replaced or modified, a consensus has not developed on a long-term solution. Part of the problem is that any permanent change is very costly. This reflects the fact that the Congressional Budget Office (CBO) baseline (based on current law requirements) assumes a reduction in the conversion factor will occur for the next several years. Further, TRHCA specified that the override of the statutory formula was to be treated as if it did not occur. Therefore, the starting base for the 2008 calculation was 5% below the actual 2007 conversion factor. MMSEA overrode the reduction for the first six months of 2008 and provided for a 0.5% increase for that period. However, the legislation again specified that override of the statutory formula is to be treated as if

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[15] U.S. Government Accountability Office (GAO), *Medicare Physician Payments: Trends in Utilization, Spending and Fees Prompt Consideration of Alternative Payment Approaches*, testimony of Bruce Steinwald before House Energy and Commerce Committee, July 25, 2006.

it did not occur. MIPPA again specifies that the override of the statutory formula is to be treated as if it did not occur. As previously noted, CBO estimates that the statutory formula will result in a reduction in the conversion factor of 21% in 2010.

In addition to its impact on federal outlays, any change in the update formula will also have implications for beneficiaries. Because beneficiary premiums equal 25% of program costs, any overall increase in spending results in a proportional increase in premiums.

Suggested modifications have ranged from modifying the current formula to replacing the formula and linking updates to payment adequacy and/or quality measures. 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, such as removing Part B drugs from the calculation, could somewhat moderate the negative updates that are predicted.

The following outlines recent alternatives to the current SGR calculation that have been presented by the Medicare Payment Advisory Commission (MedPAC), the Government Accountability Office (GAO) and CBO. Also noted are proposed modifications contained in the House-passed Children's Health and Medicare Protection Act of 2007 (CHAMP, H.R. 3162).

Medicare Payment Advisory Commission (MedPAC). For several years, MedPAC has recommended repealing the SGR system. It has recommended updating 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. Specifically, input prices would be measured using the MEI (without regard to the CMS adjustment for productivity increases). The recommended productivity adjustment would be that used across all provider services.[16]

DRA required MedPAC to submit a report to Congress on mechanisms that could be used to replace the sustainable growth rate system. The report, issued March 1, 2007, did not recommend one specific course of action but rather outlined two broad approaches as follows:

> The Congress, then, must decide between two paths. One path would repeal the SGR and not replace it with a new expenditure target. Instead, the Congress would accelerate development and adoption of approaches for improving incentives for physicians and other providers to furnish higher quality care at a lower cost. If it pursues this path, the Congress would need to make explicit decisions about how to update physician payments. Alternatively, the Congress could replace the SGR with a new expenditure target system. A new expenditure target would not reduce the need, however, for a major investment in payment reform. Regardless of the path chosen, Medicare should develop measures of practice styles and report the information to individual physicians. Medicare should also create opportunities for providers to collaborate to deliver high quality care while restraining resource use.

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[16] MedPAC, *Report to the Congress, Medicare Payment Policy*, March 2008.

> If the Congress chooses to use expenditure targets, the Commission has concluded that such targets should not apply solely to physicians. Rather, they should ultimately apply to all providers. Medicare has a total cost problem, not just a physician cost problem. Moreover, producing the optimal mix of services requires that all types of providers work together, not at cross purposes.[17]

Government Accountability Office (GAO). In its October 2004 report and subsequent July 2006 testimony, GAO outlined two main approaches for addressing current SGR issues. The first approach would retain the targets but modify the current formula. Formula modifications could include ceasing recoupment from prior periods, eliminating the cumulative target mechanism and returning to a system of annual targets, modifying the allowance for volume and intensity growth to more closely reflect technological innovation and changes in medical practice, and removing drugs from the calculation.[18]

The second approach would end targets as an explicit measure for moderating spending growth. Updates would be based on cost increases with the possibility of specifically addressing high volume service categories such as medical imaging.

Congressional Budget Office (CBO). In March 2008, CBO issued cost estimates for a variety of approaches for dealing with the physician payment issue.[19] Proposals with modest costs assumed a freeze for the second half of 2008 (as opposed to a 10.6% reduction), with reductions in future years to hold future rates at current law levels. More costly alternatives would freeze or increase payments over the 10-year budget window. For example, increasing payments by the MEI each year through 2018 would increase federal spending by $288.1 billion for the FY2008-2018 period. Coupling this with a provision excluding this change from beneficiary premium calculations ("premium hold-harmless") would increase federal spending by $364.3 billion over the same period.

House-Passed Children's Health and Medicare Protection Act of 2007 (CHAMP, H.R. 3162). The House-passed CHAMP bill, in addition to averting near term cuts in the conversion factor, also contained several provisions designed to modify the current SGR system. The bill would create six new categories of physicians' services: evaluation and management services for primary care and for preventive services; other evaluation and management services; imaging services and diagnostic tests; major procedures; anesthesia services; and minor procedures and other services. The single conversion factor currently applied to all physician services would be eliminated. Instead, a separate conversion factor would be established for each of the six newly created service categories. The bill would

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[17] MedPAC. *Assessing Alternatives to the Sustainable Growth Rate System*, testimony before Senate Committee on Finance, March 1, 2007.

[18] (1) U.S. Government Accountability Office, *Medicare Physician Payments: Concerns About Spending Target System Prompt Interest in Considering Reforms*, October 2004; and (2) GAO, *Medicare Physician Payments: Trends in Utilization, Spending and Fees Prompt Consideration of Alternative Payment Approaches*, testimony of Bruce Steinwald before House Energy and Commerce Committee, July 25, 2006.

[19] [http://www.cbo.gov/ftpdocs/90xx/doc9055/03-14-SGR_Options.pdf]

require the Secretary to establish an expert panel to identify misvalued RVUs for physicians' services, particularly those that are overvalued, and to assess whether those misvalued services warrant review through existing processes. The Secretary would be given the authority to reduce the work RVUs for a particular physicians' service if the annual rate of growth in expenditures for the service provided under Medicare for 2006 or a subsequent year exceeded the average annual rate of growth in expenditures for all Medicare physicians' services by more than 10 percentage points. The bill would also require the Secretary to develop and implement a physician feedback mechanism to measure resource use on a per capita and an episode basis and create incentive payments under the Medicare program for physicians practicing in an area identified as an efficient area.

Recent Actions

Evidence-Based Medicine; TRHCA. In recent years, increasing attention has been focused on the rapid increase in volume and intensity of services. Attention has also been directed toward the 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 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").[20]

In January 2006, CMS launched the Physician Voluntary Reporting Program (PVRP). Under this program, physicians who chose to participate reported on 16 evidence-based quality measures. The list of quality measures was subsequently modified and expanded to 66. CMS replaced the PVRP program with the Physician Quality Reporting Initiative (PQRI), as required by TRHCA.

TRHCA[21] authorized a bonus payment for physicians who reported on quality measures. Specifically, physicians and practitioners who voluntarily reported quality information are eligible for a bonus incentive payment. For services furnished from July 1, 2007 to December 31, 2007, the bonus is 1.5% of allowed charges (subject to a limit) for services for which consensus-based quality measures were established. The payments are to be made in mid-2008. The quality measures were those identified under the PVRP, as published on the CMS website on December 20, 2006 (the date of enactment). The Secretary could modify such measures up until July 1, 2007. The final 2007 list included 74 measures.

TRHCA specified that for 2008, the quality measures would be those that were adopted or endorsed by a consensus organization, that included measures submitted

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[20] For a discussion of Medicare P4P initiatives and issues, see CRS Report RL33713, *Pay-for-Performance in Health Care*, by Jim Hahn.

[21] See **Appendix B** for further detail.

by a physician specialty, and the Secretary identified as having used a consensus-based process for developing the measures. The final 2008 physician fee schedule rule specified the 119 measures that CMS identified as appropriate for use by eligible professionals to submit quality data under the PQRI in 2008.

TRHCA did not specifically link quality reporting to bonus payments for 2008. However, MMSEA extended the bonus payments for quality reporting occurring in 2008, with the payment for 2008 to be made in 2009. The cap on bonus payments to individual physicians was removed. MIPPA extends the provision through 2010, with incentive payments equal to 1.5% in 2008 and 2.0% in 2009 and 2010.

Other Issues

2007 and 2008 Fee Schedules

When the 2007 fee schedule regulation was released in November 2006, it was assumed that there would be a negative update in the conversion factor. Instead, TRHCA froze the 2007 factor at the 2006 level. In addition, the law set the work geographic adjustment level at a minimum of 1.0, thereby slightly increasing the payment amounts in some areas.

However, the rest of the 2007 fee schedule regulation continued to apply. It should be noted that this regulation incorporated several significant changes from 2006. First, it reflected the required five-year review of work relative values. Second, it incorporated the first year of a four-year phase-in of a revised methodology for calculating practice expenses. (See **Appendix D**.) Third, it included the impact of the DRA mandated changes for payments for imaging services. (See discussion, below.)

The net impact of these changes for an individual physician varied by the types and mix of services provided. The final rule for 2007 included a table showing, by specialty, the estimated impact of these changes. CMS released this table again following enactment of TRHCA. Without any change in the conversion factor, CMS estimated that five specialties would see an increase of 5% or more (emergency medicine, endocrinology, family practice, infectious diseases, and pulmonary diseases), while 10 specialties and practitioners would see a reduction of 5% or more (anesthesiology, interventional radiology, pathology, radiology, vascular surgery, chiropractors, clinical psychologists, clinical social workers, nurse anesthetists, and physical and occupational therapists). The largest reduction (13%) was for diagnostic testing facilities.

When CMS issued the final fee schedule for 2008, it was assumed there would be a 10.1% drop in the conversion factor. As noted, there is a 0.5% increase for 2008. However, during that period, other factors will continue to have an impact on payments to physicians, including any additional modifications to relative values for services provided by individual physicians, the second year of the four-year phase-in of revised methodology for calculating practice expenses, and the impact of DRA changes for payments for imaging services.

Imaging Services

MedPAC and other observers have expressed concerns that sizeable volume increases, particularly for imaging services, needed to be addressed. Part of the increases in volume may be attributable to beneficial uses of new technology; however, not all increases may be appropriate. DRA modified the payment rules for certain imaging services. Specifically, the law capped the technical component of the payment for services performed in a doctor's office at the level paid to hospital outpatient departments for such services. The limitation does not apply to the professional component (i.e., the physician's interpretation). Services subject to the cap are: X-rays, ultrasound (including echocardiography), nuclear medicine (including positron emission tomography), magnetic resonance imaging, computed tomography, and fluoroscopy. Diagnostic and screening mammography are excluded. The provision was effective January 1, 2007. A number of groups objected to the payment cuts. They contend that the cuts could have unintended consequences, including potentially diminishing access to imaging services outside of the hospital setting.

MIPPA specifically addresses the imaging issue. It provides that, beginning January 1, 2012, payment may only be made under the physician fee schedule for the technical component of advanced diagnostic imaging services furnished by a supplier if such supplier is accredited by an accreditation organization. The provision further requires the Secretary to conduct a demonstration using specified models to collect data regarding physician compliance with appropriateness criteria for advanced diagnostic imaging services. The Secretary could focus the demonstration project, such as on services that account for a large amount of Medicare expenditures, services that have recently experienced a high rate of growth, or services for which appropriateness criteria exist. (For further details, see Section 135 of MIPPA summary, below).

Impact of Spending Increases on Part B Premiums

Payments for services paid under the physicians' fee schedule account for about one-third of Part B costs.[22] 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. (About 5% of enrollees pay higher premiums based on their higher incomes.) The 2008 amount ($96.40) was computed prior to passage of the MMSEA and MIPPA provisions providing for a 0.5% increase rather than a 10.1% decrease in the conversion factor for 2008 and a 1.1% increase, rather than a decrease for 2009. These provisions have the effect of increasing Part B costs for 2008 and 2009 and, by extension, the Part B premium. The increase will first be reflected in the 2009 premium calculation.

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

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, (and the freeze in 2006 and 2007), some physicians claimed that program payments continued to fall significantly short of expenses. They suggested that problems would be magnified if the cuts, scheduled to begin in 2008, were allowed to go into effect. As noted, MMSEA delayed the cuts for six months. Physicians continue to state that access problems will definitely occur if Congress does not address the cut in the conversion factor slated to go into effect for the second half of 2008.

Access to care can be measured by reviewing beneficiary ability to get an appointment with a physician, the supply of physicians seeing Medicare patients, and physicians' willingness to see new patients.

Access. Periodic analyses by MedPAC show that beneficiary access to physicians' services is generally good. MedPAC's 2008 report reviewed several surveys conducted between 2005 and 2007.[23] The surveys 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 (82%) had no problem or only a small problem in getting an appointment with a new primary care physician, while 17% reported a big problem. 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. However, MedPAC noted that in view of possible negative updates in the second half of 2008 and in 2009, it planned to closely monitor access over the next year.

Physician Supply. MedPAC reports that the growth in the number of physicians regularly billing Medicare fee-for-service patients has kept pace with the growth in the Medicare population. MedPAC reports that from 2001 to 2006, the number of physicians with at least 15 Medicare patients grew 8.7% from 457,292 to 497,072; over the same period the number of such physicians per 1,000 beneficiaries grew from 12.1 to 12.3. Further, the number of physicians with 200 or more Medicare patients grew 12.9%.[24]

Physicians' Willingness to See New Beneficiaries. A related concern is the possible decline in the percentage of physicians accepting new Medicare patients. However, MedPAC reports that the large majority of physicians in the U.S. are willing to accept new Medicare patients. It cites results from a 2006 MedPAC-

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[23] MedPAC, March 2008.

[24] MedPAC, March 2008.

sponsored survey showing that most (97%) of physicians accept at least some new Medicare fee-for-service patients, with a smaller share (80%) accepting all or most.

GAO Study. MMA required GAO to study and report to Congress on beneficiary access to physicians' services. The study was issued in July 2006.[25] It found that from 2000 through 2004, among beneficiaries who needed access to physician services, the percentages reporting major difficulties in finding a provider or being able to schedule an appointment remained relatively constant (about 7% nationwide). Similar percentages were reported for urban and rural beneficiaries. Beneficiaries who rated their health as poor, were under 65 and disabled, were not white, and had no supplemental health insurance or had supplemental insurance from Medicaid, were more likely to have experienced physician access difficulties. GAO further noted that the proportion of beneficiaries who received services and the number of services provided to beneficiaries who were treated suggested an increase in access from April 2000 to April 2005.

Future Prospects. While access remains good for Medicare beneficiaries, many observers are concerned that the situation could change if future cuts slated to occur through application of the SGR methodology are allowed to occur. MedPAC does not support the consecutive annual cuts called for in the law. It is concerned that such cuts could threaten beneficiary access to physicians' services over time, particularly those provided by primary care physicians.

On June 26, 2008, the AMA issued a statement that, based on a physician survey, if the cut in the conversion factor were allowed to go into effect July 1, 2008, 60% of physicians would limit the number of new Medicare patients they treat, more than half would need to cut staff, and 14% would quit patient care altogether.[26]

Geographic Variation in Payments

Geographic Cost Indices. Medicare makes a geographic adjustment to each component of the physician fee schedule.[27] 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, the freeze in 2006 and 2007, and the prospects of further reductions in future years.

MMA made temporary 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 applied from 2004-2006. TRHCA extended the provision for an additional year — through 2007.

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[25] GAO, *Medicare Physician Services: Use of Services Increasing Nationwide and Relatively Few Beneficiaries Report Major Access Problems*, GAO-06-704, July 21, 2006.

[26] [http://www.ama-assn.org/ama/pub/category/18733.html]

[27] See **Appendix A** for a discussion of how these adjustments are calculated.

MMSEA extended it for an additional six months — through June 30, 2008. MIPPA extends it through 2009.

MMA further directed the GAO to conduct a study of the geographic adjusters. A GAO report issued in March 2005 concluded that all three adjusters were valid in their fundamental design, and appropriately reflected broad patterns of geographic differences in running a practice. The report made several recommendations for improving the data and methods used to construct the data. CMS stated that implementing many of the recommendations was not feasible at that time.[28]

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, 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 has stated that it will 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.

In June 2007, the GAO issued a report that stated that more than half of the current payment localities had counties within them with a payment difference of at least 5% between GAO's measure of physicians' costs and Medicare's geographic adjustment for the area. A disproportionate number of these counties were located in five states. GAO recommended that CMS revise the localities using an approach uniformly applied in all states and based on the most current data. It further recommended that the localities be updated on a periodic basis. CMS stated that it would consider the first recommendation but would continue its policy of updating the localities when interested parties raised concerns or on its own initiative.[29]

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[28] U.S. GAO, *Medicare Physician Fees: Geographic Adjustment Indices are Valid in Design, but Data and Methods Need Refinement*, GAO Report 05-119, March 2005.

[29] U.S. GAO, *Geographic Areas Used to Adjust Physician Payments for Variation in Practice Costs Should Be Revised*, GAO Report 07-466, June 2007.

California Issues. Two counties in California (Santa Cruz and Sonoma) are assigned to a larger payment locality ("rest of California"). As a result, they have geographic payment adjusters that are much lower than would be in place if they had county-specific adjusters. Their adjusters are also substantially lower than those applicable in neighboring counties. In the August 8, 2005 proposed physician fee schedule, CMS offered a proposal to address the problem. However, it failed to win the support of the majority stakeholders because offsetting reductions would be required in other areas in the state. The final regulation, therefore, included no change for 2006.

The proposed 2008 fee schedule regulation issued July 12, 2007, identified three options for possible locality reconfigurations in California. CMS stated that it was soliciting comments and was considering possibly adopting one of the approaches in the final rule. However, in view of the variety of comments received from interested parties in both California and other states, it decided further study was needed. Therefore, no change was made for 2008.

Medicare Versus Private Payment Rates

Some persons contend that Medicare payments lag behind those in the private sector. MedPAC's 2008 report notes that the difference between Medicare and private rates narrowed in the late 1990s and has remained relatively stable in recent years. Averaged across all services and areas, the 2006 rates were 81% of private fees. The 2006 rate was lower than the 83% ratio for 2005; MedPAC stated that this might be partially attributable to the 0% update in the conversion factor for 2006. It should be noted that difference in fees can vary markedly within a market area and for a given service.

Payments for Oncology Services

The level of payments for practice expenses became a major issue for oncologists who frequently administer chemotherapy drugs in their offices. Prior to the implementation of the new Medicare drug program under Part D, Medicare did not cover most outpatient prescription drugs. However, certain categories of these drugs have been and continue to be covered under Part B. Included are drugs that cannot be self-administered and which are provided as incident to a physician's service, such as chemotherapy. Medicare Part B also covers certain oral cancer drugs. Covered drugs are those that have the same active ingredients and are used for the same indications as chemotherapy drugs which would be covered if they were not self-administered and were administered as incident to a physician's professional service.

Prior to enactment of MMA, a number of reports, including those by the HHS Office of Inspector General, the Department of Justice (DOJ), and GAO had 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 had 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 sought to rationalize program payments. It increased the payments associated with drug administration services. At the same time, it revised the way covered Part B drugs are paid.[30] Beginning in 2005, drugs are paid using the average sales price (ASP) methodology; in general drug payments equal 106% of the manufacturer reported ASP. Drug payments are less under the new system. A transitional payment was authorized in 2004 and 2005 to ease the adjustment. In addition, in 2005 and 2006, CMS authorized demonstration projects under which oncologists who reported certain information received additional payments. These demonstration projects are no longer in place.

Many observers suggested that changes to the drug payment methodology were long overdue and that reductions were in order given the previous overpayments. However, a number of industry groups stated that the revised payments did not adequately cover the costs associated with administration and purchase of drugs. A number of oncologists stated that they were unable to purchase drugs at or below the MMA established rates.

In July 2007, the OIG for HHS issued a report[31] examining these concerns. The report reviewed 12 physician practices in the specialties of hematology, hematology/oncology, and medical oncology. It noted that because 11 of the 12 practices did not have procedures to track, by procedure code, the costs associated with administering drugs to cancer patients, it could not determine whether Medicare reimbursement for each code was sufficient to cover the costs of providing the services.

The OIG further noted that 9 of the 12 practices reviewed could generally purchase drugs related to selected payment codes for treatment of cancer patients at or below the MMA-established rates during the second quarter of 2005 (the report's review period). The remaining three practices paid prices above the reimbursement rates for at least half of the selected codes related to the purchased drugs. The report did not provide an explanation for the differences, but did state that, based on its analysis, that there were no significant differences in results due to practice size or location.

Concierge Care

In recent 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.

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

[31] HHS, Office of Inspector General, *Review of Selected Physician Practices' Procedures for Tracking Drug Administration Costs and Ability to Purchase Cancer Drugs at or Below Medicare Reimbursement Rates*, OIG Report A-09-05-00066, July 2007. [http://www.oig.hhs.gov/oas/reports/region9/90500066.pdf].

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.

Recent Legislation

Changes Made by MMA, DRA, TRHCA

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. DRA revised the update calculation for 2006 and modified payments for imaging services. TRHCA modified the calculation for 2007 and established a fund to promote payment stability and physician quality initiatives in 2008. (For a summary of these provisions, see **Appendix B**.)

Legislation in the First Session of the 110th Congress

On August 1, 2007, the House passed the Children's Health and Medicare Protection Act of 2007 (CHAMP). This legislation included a number of Medicare provisions including several relating to payments under the physician fee schedule; it also included provisions extending the State Children's Insurance Program (SCHIP).[32] Subsequently, Congress passed, and the President vetoed, two bills dealing only with SCHIP.

During the fall of 2007, Senate Finance Committee members attempted to come to an agreement on a Medicare package. Of particular concern was the looming cut in the 2008 conversion factor; the discussion was complicated by the cost associated

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[32] For a summary of CHAMP, see CRS Report RL34122, *H.R. 3162: Provisions in the Children's Health and Medicare Protection Act of 2007*.

with any potential payment "fix." The committee members were unable to come to an agreement, and no committee markup was held.

However, during the last days of the first session of the 110th Congress, House-Senate negotiators came to agreement on a narrowly focused bill addressing both the Medicare physician payment issue and SCHIP. The Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA, enacted December 29, 2007) provided for a temporary 0.5% increase in the conversion factor for the six-month period beginning January 1, 2008. It also extended, for the same six-month period, provisions setting the geographic work adjustment at 1.0 and providing bonus payments in scarcity areas. (See **Appendix B.**)

Children's Health and Medicare Protection Act of 2007 (CHAMP, H.R. 3162), as Passed by the House. MMSEA included a limited number of Medicare provisions; a major focus was averting the cut in the conversion factor slated to occur January 1, 2008. However, the House-passed CHAMP bill was still considered the House approach on more long-term program revisions. Proposed longer-term revisions included (1) creating six new categories of physicians' services (evaluation and management services for primary care and for preventive services; other evaluation and management services; imaging services and diagnostic tests; major procedures; anesthesia services; and minor procedures and other services); (2) eliminating the single conversion factor currently applied to all physician services and establishing a separate conversion factor for each of the six newly created service categories; (3) improving the accuracy of relative values by requiring the Secretary to establish an expert panel to identify misvalued physicians' services, particularly those that are overvalued, and assessing whether those misvalued services warrant review through existing processes; (3) giving the Secretary the authority to reduce the work RVUs for a particular physicians' service if the annual rate of growth in expenditures for the service provided under Medicare for 2006 or a subsequent year exceeded the average annual rate of growth in expenditures for all Medicare physicians' services by more than 10 percentage points; (4) requiring the Secretary to develop and implement a physician feedback mechanism to measure resource use on a per capita and an episode basis; (5) creating incentive payments under the Medicare program for physicians practicing in areas identified as an efficient area; (6) requiring the Secretary to analyze and recommend ways to consolidate coding for procedures and to increase use of bundled payments under the fee schedule; (7) expanding the medical home demonstration project established by TRHCA; (8) adjusting Medicare payment localities; and (9) extending the bonus payments for physician scarcity areas.

For more detail on the CHAMP provisions, see CRS Report RL34122, *H.R. 3162: Provisions in the Children's Health and Medicare Protection Act of 2007*.

Legislation in the Second Session of the 110th Congress: MIPPA

The major focus during the second session of the 110th Congress was the looming cut in the conversion factor, effective July 1, 2008. On June 6, 2008, Senator Baucus, Chairman of the Senate Finance Committee, introduced S. 3101, the

Medicare Improvements for Patients and Providers Act of 2008. On June 24, 2008, the House passed a modified version of the Baucus bill under suspension of the rules by a vote of 355 to 59. On July 9, 2008, the Senate passed the bill without amendment by unanimous consent and the bill was cleared for the White House. On July 15, 2008, President Bush vetoed the bill, primarily because of provisions cutting Medicare Advantage payments. On the same day, the House voted 383-41 to override the veto, and the Senate later voted 70-26 to override the veto. MIPPA became law as P.L. 110-275. The following is a brief summary of the bill's provisions dealing with physicians[33].

Section 131. Physician Payment, Efficiency, and Quality Improvements. This provision freezes the conversion factor at the level in place in June 2008 through the end of the year. In January 2009, the conversion factor increases by 1.1%. In 2010, fees revert back to current law levels, resulting in a 21% reduction in fee levels, according to CBO.

This provision modifies the physician assistance and quality initiative fund, effectively eliminating monies from the fund in 2013 and 2014. As modified by the Supplemental Appropriations Act, 2008 (P.L. 110-252), $4.96 billion are removed from the fund in those years and returned to the Medicare Part A and Part B Trust Funds, to be made available for other purposes.

The provision also (1) extends and modifies the physician quality reporting system, which currently runs through 2009; (2) establishes a physician feedback program, with the intent to improve efficiency and to control costs; and (3) requires the Secretary to develop a plan to transition to a value-based purchasing program for payment under the Medicare program for covered professional services.

Section 132. Incentives for Electronic Prescribing. The provision establishes incentives for electronic prescribing in the Medicare program. For 2009 through 2013, Medicare professionals providing covered services to Medicare beneficiaries and who are successful electronic prescribers will receive an incentive payment of 2.0% for 2009 and 2010, 1.0% for 2011 and 2012, and 0.5% for 2013. Providers who do not have a sufficient volume of qualifying services will be excluded from the program, as well as those for whom the Secretary determines that compliance would be a significant hardship, such as for an eligible professional who practices in a rural area without sufficient Internet access. Not later than September 1, 2012, the GAO is required to submit a report to Congress on the implementation of the incentives for electronic prescribing established by this section.

Section 133. Expanding Access to Primary Care Services. The provision gives the Secretary the authority to expand the duration and scope of the Medical Home Demonstration Project if the expansion would meet either of the following conditions: (1) the expansion of the project is expected to improve the quality of patient care without increasing spending under Medicare, or (2) the expansion of the project is expected to reduce spending under the Medicare program

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[33] For a summary of MIPPA, see CRS Report RL34592, *P.L. 110-275: The Medicare Improvements for Patients and Providers Act of 2008*, by Hinda Chaikind et al.

without reducing the quality of patient care. To fund any potential expansion of the demonstration project, $100 million would be made available from the Federal Supplementary Medical Insurance Trust Fund.

Traditionally, the required "budget neutrality" requirement has been implemented through an adjustment to the conversion factor. However, beginning in 2007, CMS made the adjustment to work relative values. The provision changes the application of the adjustor back to the conversion factor, beginning with 2009.

Section 134. Extension of Floor on Medicare Work Geographic Adjustment under the Medicare Physician Fee Schedule. The provision extends the temporary floor of 1.00 on the geographic work adjustment through December, 2009. In addition, beginning January 1, 2009, it raises the work geographic adjustment to 1.5 in Alaska if the index would otherwise be less than 1.5.

Section 135. Imaging Provisions. The provision specifies that beginning January 1, 2012, payment may only be made under the physician fee schedule for the technical component of advanced diagnostic imaging services furnished by a supplier if such supplier is accredited by an accreditation organization. Advanced diagnostic imaging services are defined as including diagnostic magnetic resonance imaging, computed tomography, and certain other services as specified by the Secretary in consultation with physician specialty organizations and other stakeholders. The accreditation organization would have to be designated by the Secretary, who is required to consider specified factors both in designating an accreditation organization and in reviewing and modifying the list of designated organizations.

The Secretary is required to establish procedures to ensure that the criteria used by an accreditation organization to evaluate a supplier that furnishes the technical component of advanced diagnostic imaging services is specific to each imaging modality.

The provision requires the Secretary to establish a two-year demonstration project using specified models to collect data regarding physician compliance with appropriateness criteria for advanced diagnostic imaging services. The Secretary could focus the demonstration project, such as on services that account for a large amount of Medicare expenditures, services that have recently experienced a high rate of growth, or services for which appropriateness criteria exist. The Secretary, in consultation with medical specialty societies and other stakeholders, is to select criteria with respect to the clinical appropriateness of advanced diagnostic imaging for use in the demonstration. The Secretary will develop mechanisms to provide feedback reports to physicians participating in the project. In addition, the Secretary will be required to evaluate the demonstration project and to submit a report to Congress containing the results of the evaluation together with recommendations for legislative and administrative action.

The GAO is required to conduct a study by imaging modality of the new accreditation requirement and any other relevant questions involving access to and the value of advanced diagnostic imaging services for beneficiaries.

Section 136. Extension of Treatment of Certain Physician Pathology Services under Medicare. Legislation enacted in 1997 specified that independent labs that had agreements with hospitals on July 22, 1999, to bill directly for the technical component of pathology services could continue to do so in 2001 and 2002. The provision has been periodically extended, most recently through June 30, 2008. The provision extends it through December 31, 2009.

Section 137. Accommodation of Physicians Ordered to Active Duty in the Armed Services. Medicare payment may be made to a physician for services furnished by a second physician to patients of the first physician provided certain conditions are met. In general, the services cannot be provided by the second physician for more than 60 days. The law had permitted, for services provided prior to June 30, 2008, reciprocal billing over a longer period in cases where the first physician was called or ordered to active duty as a member of a reserve component of the Armed Forces. The provision makes the accommodation permanent.

Section 138. Adjustment for Medicare Mental Health Services. Medicare pays for mental health services under the physician fee schedule. The provision increases the fee schedule amount otherwise applicable for certain specified mental health services by 5% for the period July 2008-December 2009.

Section 139. Improvements for Medicare Anesthesia Teaching Programs. Anesthesia services may be personally performed by the anesthesiologist, or the anesthesiologist may medically direct up to four concurrent anesthesia cases. When the anesthesiologist medically directs a case, the payment for the physician's medical direction service is 50% of the amount otherwise recognized if the anesthesiologist personally performed the service. The provision establishes a special payment rule with respect to physicians' services furnished on or after January 1, 2010. In the case of teaching anesthesiologists involved in a single anesthesia case or two concurrent anesthesia cases, the payment amount will be 100% of the fee schedule amount otherwise applicable if the anesthesia services were personally performed by the teaching anesthesiologist alone. This payment provision will apply only if (1) the teaching anesthesiologist is present during all critical or key portions of the anesthesia service or procedure involved, and (2) the teaching anesthesiologist (or another anesthesiologist with whom the teaching anesthesiologist had entered into an arrangement) is immediately available to furnish anesthesia services during the entire procedure. Further, the provision requires the Secretary to make appropriate payment adjustments for items and services furnished by teaching certified registered nurse anesthetists.

Appendix A. Calculation of the Physician Fee Schedule Update

Calculation of the Physician Fee Schedule

General Formula. The following is the *general* payment formula for a service under the physician fee schedule:

$$\text{Payment} = [(RVU_w \times GPCI_w) + (RVU_{pe} \times GPCI_{pe}) + (RVU_{mal} \times GPCI_{mal})] \times CF$$

Where:
- RVU_w = relative value unit for work
- RVU_{pe} = relative value unit for practice expenses
- RVU_{mal} = relative value unit for malpractice expenses
- $GPCI_w$ = geographic practice cost index for work
- $GPCI_{pe}$ = geographic practice cost index for practice expenses
- $GPCI_{mal}$ = geographic practice cost index for malpractice expenses
- CF = conversion factor

2008 Calculation. The law contains a budget neutrality provision, which specifies that changes to relative value units under the fee schedule cannot cause expenditures to increase or decrease by more than $20 million from the amount of expenditures that would otherwise have been made. In the past, the budget neutrality requirement was implemented through an adjustment to the conversion factor; however, beginning in 2007, it is implemented through an adjustment to work relative values. Therefore, the following is the formula applicable for 2008:

2008 Payment $= [(\{RVU_w \times BNA_{08}$ - round product to 2 decimal places$\} \times GPCI_w) + (RVU_{pe} \times GPCI_{pe}) + (RVU_{mal} \times GPCI_{mal})] \times CF$

Where: BNA_{08} = budget neutrality adjuster for 2008 (0.8806)

Note that the practice expense relative value for a service may vary by whether the non-facility or facility pricing amount is used.

Calculation of the Update to the Conversion Factor (CF)

General Formula. The conversion factor is a dollar figure that converts the geographically adjusted relative value for a service into a dollar payment amount. The following is the *general* formula for the annual update to the conversion factor:

$$CF_{\text{current year}} = CF_{\text{prior year}} \times \text{CF update}$$

$$\text{CF update} = (1 + \text{MEI increase}/100) \times (1 + \text{UAF})$$

Where:
- *Medicare Economic Index (MEI)* - measures the weighted average annual price changes in the inputs needed to produce services
- *Update Adjustment Factor (UAF)* - makes actual expenditures and target (allowed) expenditures equal

2008 Calculation. The calculation of the conversion factor for 2008 that *would have applied in the absence of MMSEA and MIPPA* is more complicated than the general formula because by law the 2007 update provided by TRHCA is assumed not to have occurred. The following is the calculation for this 2008 calculation.

$CF_{2008} = CF_{2007pre\text{-}TRHCA}$ x CF update
= $CF_{2007pre\text{-}TRHCA}$ x (1 + MEI increase/100) x (1+ UAF)
= $35.9848 x (1 +1.8/100) x (1 + (-0.7))
= $35.9848 x (1.018 x .930)
= $35.9848 x -5.3% (0.94674)
= $34.0682

Where: $CF_{2007pre\text{-}TRHCA}$ = $35.9848
MEI = 1.018%
UAF = -7.0%

Note that the $34.0682 figure would have been a 10.1% reduction from the $37.8975 CF that was in place for 2007 after enactment of TRHCA.

Calculation of the Update Adjustment Factor (UAF)

The SGR system is used to determine allowable expenses; these are compared with actual expenditures to determine the UAF. The formula includes both a prior year adjustment and a cumulative adjustment.

UAF = Prior Year Adjustment Component + Cumulative Adjustment Component

The formula for 2008 was calculated as follows:

UAF_{08} = $[(Target_{07} - Actual_{07}) / Actual_{07}] \times 0.75 +$
$[(Target_{4/96\text{-}12/07} - Actual_{4/96\text{-}12/07}) / (Actual_{07} \times SGR_{08})] \times 0.33$

Where: $Target_{07}$ = $83.9B
$Actual_{07}$ = $94.6 B
$Target_{4/96\text{-}12/07}$ = $776.6 B
$Actual_{4/96\text{-}12/07}$ = $828.8 B
SGR_{07} = - 0.1% (0.999)

UAF_{08} = [($83.9B - $94.6B)/$94.6B x .75] +
[($776.6B - $828.8B/ ($94.6 x 0.999) x 0.33]

= (-0.113 x .75) + (-.552 x .33) = -0.267

However: UAF cannot be less than - 0.07 or greater than + 0.3; therefore:

UAF_{08} = - 0.07

Appendix B. MMA, DRA, TRCHA, and MMSEA Provisions Relating to Physicians

MMA

MMA made several changes in the calculation of the fee schedule. Over the short term, generally 2004-2005, they were designed to increase program payments to physicians. The following were the key changes:

- The update to the conversion factor could be no less than 1.5% in 2004 and 2005. (Section 601(a) of MMA.)
- The formula for calculating the sustainable growth rate (SGR) was 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 were each raised to 1.67 for 2004 and 2005. This resulted in an increase in payments to Alaska physicians in these years. (Section 602 of MMA.)
- A floor of 1.00 was set on the geographic work adjustment for the 2004-2006 period. (Section 412 of MMA.)
- An additional 5% in payments was provided for certain physicians in scarcity areas for the period January 1, 2005-December 31, 2007. The Secretary was 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 would be revised no less often than once every three years unless there was no new data. (Section 413 of MMA.)

MMA also revised the way covered Part B drugs were paid under the program; this had the effect of lowering program payments for the actual drugs.[34] At the same time, MMA increased the payments associated with drug administration services. These provisions affected selected specialties, primarily oncologists.

MMA also required a number of studies and reports relating to physicians' services. These were intended to provide Congress with additional information as it considered revisions in the current payment formula.

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

- Podiatrists, dentists, and optometrists were permitted to enter into private contracting arrangements. (Section 603 of MMA.)

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

- Medicare payments could 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 would have to meet program integrity and other standards specified by the Secretary. (Section 952 of MMA.)
- The Secretary was required to use a consultative process prior to implementing any new documentation guidelines for evaluation and management (i.e., visit) services. (Section 941 of MMA)
- MMA contained a number of additional provisions designed to address physicians' concerns with regulatory burdens. (Title IX of MMA.)

DRA

DRA froze the 2006 fee schedule at the 2005 level. It required MedPAC to submit a report to Congress by March 1, 2007 on mechanisms that could be used to replace the sustainable growth rate system.

DRA also modified payments for imaging services. It capped the technical component of the payment for services performed in a doctor's office. The cap is set at the outpatient department (OPD) fee schedule amount (without regard to the geographic wage adjustment factor) under the prospective payment system for hospital outpatient departments. The law also included a technical provision specifying that an earlier regulation change made by CMS for multiple imaging procedures was not to be taken into account in making the budget neutrality calculation for 2006 and 2007.

TRHCA

TRHCA froze the 2007 fee schedule at the 2006 level. It also provided a bonus payment for physicians who report on quality measures. Specifically, physicians and practitioners who voluntarily report quality information will be eligible for a bonus incentive payment. For services furnished from July 1, 2007 - December 31, 2007, the bonus is 1.5% of allowed charges for services for which consensus-based quality measures have been established. The quality measures are those identified under the Physician Voluntary Reporting Program (PVRP), as published on the CMS website on December 20, 2006 (the date of enactment). The Secretary could modify these quality measures if changes were based on the results of a consensus process meeting in January 2007 and if such changes were published on the website by April 1, 2007. The Secretary could refine such measures up until July 1, 2007.

If there are no more than 3 quality measures applicable to the services furnished, the provider must report each measure for at least 80% of the cases. If there are 4 or more quality measures, the provider must report at least 3 for at least 80% of the cases. The Secretary would presume that if an eligible professional submits data for a measure, then the measure is applicable to the professional. The Secretary may validate this presumption by sampling or other means.

The Secretary is to estimate, based on submitted claims, an amount equal to 1.5% of allowed charges for services for which reports have been made. A *single consolidated bonus payment* is to be made to the physician for the July 1, 2007 - December 31, 2007 reporting period. No provider could receive payments in excess of the product of the total number of quality measures for which data are submitted and three times the average per measure payment amount. The average per measure payment amount (as estimated by the Secretary) is the total amount of allowed charges under Part B for all covered services furnished during the reporting period on claims for which quality measures are reported divided by the total number of quality measures for which data are reported during the reporting period.

In 2008, the quality measures are those that have been adopted or endorsed by a consensus organization, that include measures submitted by a physician specialty, and the Secretary identifies as having used a consensus-based process for developing the measures. The measures are to include structural measures such as the use of electronic health records and electronic prescribing technology. The proposed measures for 2008 are to be published by August 15, 2007, with final measures published by November 15, 2007.

The law authorized $1.35 billion for 2008 for a Physician Assistance and Quality Initiative (PAQI) Fund which is to be available to the Secretary for physician payment and quality improvement initiatives. The initiatives may include adjustments to the conversion factor. The provision also required transfer of $60 million from the Part B trust fund to the CMS program management account for use in implementing the fee schedule and reporting provisions for FY2007 - FY2009.

The law also extended for an additional year the MMA provision setting a floor of 1.00 on the geographic component of the work adjustment.

MMSEA

MMSEA increased the conversion factor by 0.5% over the 2007 amount for the six-month period beginning January 1, 2008. Also extended for six months were the provisions setting the minimum geographic adjuster for the physician work component at 1.0 and the provision providing bonus payments in physician scarcity areas. The legislation also extended the TRHCA provision for bonus payments for quality reporting through 2008.

MMSEA modified the amounts that will be available in the PAQI Fund and the years in which the monies can be spent. However, there are provisions in the Department of Labor, Health and Human Services, and Education and Related Agencies Appropriations Act of 2008 (division G of the Consolidated Appropriations Act of 2008), and P.L. 110-90 (TMA, Abstinence Education, and QI Programs Extension Act of 2007), that also affect the PAQI Fund. The net effect of these three laws was that no funds remain available in the PAQI Fund for the years 2008 through 2012, and $4.96 billion are available in 2013. (See further change made by MIPPA in "Recent Legislation" section.) A separate provision in P.L. 110-173 also required that the amount available for expenditures during 2013 be available only for an adjustment to the update of the conversion factor for that year.

Appendix C. 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.[35]

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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[35] 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 .... [36]

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.

MMA contained several provisions relating to the geographic calculations. The law set a floor of 1.0 on the work adjustment for the 2004-2006 period. TRHCA extended the provision through 2007; MMSEA extended it through the first six months of 2008; and MIPPA extends it through 2009. MMA also raised the adjustments in Alaska for the work component, practice expense component, and malpractice component to 1.67 for the 2004-2005 period; this provision was not

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

extended. However, MIPPA specifies that beginning January 1, 2009, the work geographic adjustment is raised to 1.5 in Alaska if the index would otherwise be less than 1.5.

Calculation[37]

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 1995-1997 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 1995-1997 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 1998-2000 work indices from the indices in effect for 1995-1997. Similarly, virtually no changes were made in the 2001-2003 work indices.[38] 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

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[37] 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, November 1, 2000.

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

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 special tabulations which had not been completed in time for use in the 2004 fee schedule. The 2000 data is being used for 2005-2008. The same data sources and methodology used for the development of the 2001-2003 period were used for the subsequent periods.

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 2005-2008.

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

Malpractice component. Malpractice premiums are used for calculating the geographic indices. Premiums are for a mature "claims made" policy (a policy that covers malpractice claims made during the covered period) providing $1 million to $3 million coverage. Adjustments are made to incorporate costs of mandatory patient compensation funds. CMS updates the geographic adjuster based on the most recent premiums information.

Appendix D. 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.

HCFA developed the required new methodology which 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) were allocated to procedures based on a combination of the procedure's work relative

value units and the direct practice expense estimates. If the procedure was performed by more than one specialty, a weighted average was computed; this average was based on the frequency with which each specialty performed the procedure on Medicare patients. The final step was a budget neutrality adjustment to assure that aggregate Medicare expenses were no more or less than they would be if the system had not been implemented.

Subsequent Modifications. 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 a process under which data collected or developed outside HHS would be accepted and used to the maximum extent practicable and consistent with sound data practices. These outside data would supplement data normally developed by HHS for determining the practice expense component. Under this authority, CMS has accepted supplemental data from seven specialties.

CMS continued to refine practice expense relative value units on an ongoing basis. Assisting in this process was a multispecialty subcommittee of the AMA's RUC. This subcommittee, the Practice Expense Advisory Committee (PEAC), reviewed CPEP clinical staff, equipment, and supply data for physicians' services. It made recommendations to CMS based on this review. CMS implemented most of the refinements recommended by the RUC and PEAC. Recently, the PEAC was replaced by the Practice Expense Review Committee (PERC).

In its proposed rule-making for the 2006 fee schedule, CMS proposed to revise the calculation used to determine practice expenses. This proposal was withdrawn in the final rule, primarily because incorrect calculations were published in the proposed fee schedule. A modified version is incorporated in the 2007 fee schedule.

2007 Fee Schedule. The 2007 fee schedule incorporated a major revision in the way practice expenses are calculated. CMS stated that the revisions should make the process more transparent and easier to understand. The following are the major changes:

- Use of a "bottom-up" method to calculate direct practice expenses. CMS states that data refinements by the PEAC/PERC/RUC process has enabled it to use this approach. The direct costs are to be determined by adding the costs of the resources (clinical staff, equipment and supplies) typically required to provide the service.

- Use of practice expense survey data from eight specialties: allergy/immunology, cardiology, dermatology, gastroenterology, radiology, radiation oncology, urology and independent diagnostic testing facilities.

- Elimination of an exception to the previous methodology, the "nonphysician work pool" which was used to calculate practice expenses for service codes without a physician work component (i.e. technical component codes and codes for services furnished by

nonphysicians). These services will now be priced using the standard practice expense methodology.

- Incorporate technical modifications in the calculation of indirect practice expenses.

The changes are being phased-in over four years, 2007-2010.

Appendix E. Private Contracting Rules

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.